The Journal of
NERVOUS and MENTAL DISEASE

VOL. 130, NO. 4
April 1960
SERIAL NO. 929

BIOMETRIC EVALUATION OF AN INTENSIVE TREATMENT PROGRAM IN A STATE MENTAL HOSPITAL

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In August, 1956, a pilot program of intensive treatment for female geriatric mental patients was initiated at Central Islip State Hospital with the establishment of a Geriatric Unit. The Geriatic Unit has facilities for 76 patients, whereas the regular continued treatment services have populations of over 500. Thus while regular services can do little more than provide physical care for the patients, the Geriatric Unit has been able to offer psychotherapy, physiotherapy, occupational therapy and placement services. The intensive treatment program was not a controlled experiment, but was set up in such a way as to provide an opportunity to assess the efficacy of intensive treatment without restricting the extension of services. A clinical evaluation of the program will be presented elsewhere (2).

Statistical evaluation was made possible by the fact that the subjects, who were selected by screening new admissions, were assigned alternately to the Geriatric Unit or to the usual continued treatment services. The routinely treated alternates were evaluated as a control group for comparison with the patients in the Geriatric Unit.

SELECTION OF SUBJECTS

The following six criteria were established for the selection of the subjects who were placed alternately in the intensive treatment unit or among the controls.

1. Sixty-five years of age or older.
2. Female (Male geriatric patients admitted to this hospital were considered too unrepresentative for the study.)
3. Diagnoses of either senile psychosis, psychosis with cerebral arteriosclerosis or psychosis with cardiovascular renal disease.
4. Absence of gross organic involvement.
5. First admissions to a state mental institution.
6. Ambulatory or capable of becoming ambulatory during the first week of hospitalization.

While patients admitted to the Geriatric Unit were placed together so as to facilitate the application of intensive treatment, the controls were placed in the usual continued treatment services, being assigned to wards as far as possible according to their needs, but primarily according to the available space in the various services at the time of admission. They were in no way differentiated from other geriatric referrals with the exception that the materials to be described were used to compare their behavior and course of hospitalization with those of the patients in the intensive treatment unit. Although the intensive treatment unit was opened in August, 1956, the subjects under study were admitted between December, 1956 and December, 1957. During the first five months of its existence, the Geriatric Unit at first accepted all successively admit-

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ted patients who met the above criteria so as to assure maximum extension of available services. During this period the rating scale, which was the chief instrument for individual evaluation, was tested and adapted to its special purpose. The final biometric evaluation was a comparison of 111 subjects from the Geriatric Unit with 105 controls from the continued treatment services. Certain cases accepted for the study were subsequently found not to fit the classifications and were dropped (most of these were found to be readmissions or to be below the age of 65). Tables 1 and 2 show the final composition of the two groups.

TABLE 1
Distribution of Patients in Geriatric Unit by Age and Diagnosis

Diagnosis*	65–69	70–74	75–79	80–84	85+	Total
CAS	14	14	7	12	7	54
Senile						
Simple	5	7	6	7	6	31
Paranoid	4	3	4	3	1	15
Presbyophrenia		3	1	3	2	9
Agit. & Depr.				1	1	2
	23	27	18	26	17	111

* Three subjects found to be readmissions were dropped. One subject was not rated.

TABLE 2
Distribution of Patients in Control Group by Age and Diagnosis

Diagnosis*	65–69	70–74	75–79	80–84	85+	Total
CAS	8	14	9	10	6	47
Senile						
Simple	3	8	8	3	5	27
Paranoid	3	5	4	4	4	20
Presbyophrenia	1	3	2	1	1	8
Agit. & Depr.		1				1
Other†	1	1				2
	16	32	23	18	16	105

* Two subjects under 65 years of age were dropped. Five patients were not rated.

† One listed as hypertensive cardiovascular disease; one as "Ment Syph."

PROCEDURE

A behavioral rating scale of 112 dichotomous items was constructed for this study. The first 50 items in this scale are shown in Table 3. Each item describes a unit of behavior observable on the ward. The observers (nurses or ward attendants), after a preliminary training period, were able to mark each item as either true or not true for the patient's behavior during the first week of hospitalization. A follow-up rating was made at the end of the first month of hospitalization. The items in the rating scale included a wide range of psychopathological behavior. They were scored a priori (by face validity), unit weight being assigned to the assumed "healthy" as opposed to the "unhealthy" behavior. The behavior rating scale was thus intended to be a measure of severity of illness on admission and subsequently after four weeks of treatment. The following areas were covered in the rating scale: expressive movements, hygiene, mannerisms, activity level, memory and orientation, self-attitudes, cooperativeness, communication, contact, aggressiveness, and special symptoms of pathognomonic significance. Each item was intended to record an observable behavior or at most a first-order generalization so as to minimize inference on the part of the judges in so far as possible.

An actuarial analysis of the outcome of treatment within each group was carried out by means of a modified life table, or Outcome Table, each subject being followed to the anniversary of her admission for date and type of outcome. Separate Outcome Tables were then constructed for the intensive treatment and the control groups by combining the experiences of patients admitted in different calendar months as if all had been admitted simultaneously. An individual was counted in each successive month from entry as long as he remained under treatment. The proportions of patients with a particular outcome during their first month of hospitalization were computed by dividing the number with that outcome during their

TABLE 3

Representive Items from Rating Scale for Behavior on a Geriatric Ward

1.	YES	NO	Frequently asks for medication.
2.	YES	NO	Sleeps soundly.
3.	YES	NO	Ignores the activities around him.
4.	YES	NO	Hears voices (auditory hallucinations).
5.	YES	NO	Must be helped along to stick to any activity.
6.	YES	NO	Swears or uses obscene language.
7.	YES	NO	Makes grandiose unrealistic statements.
8.	YES	NO	Makes his own bed.
9.	YES	NO	Follows current events.
10.	YES	NO	Takes part in card games or similar social games.
11.	YES	NO	Asks if there's work to do.
12.	YES	NO	Can take kidding.
13.	YES	NO	Stays by himself.
14.	YES	NO	Needs help in dressing.
15.	YES	NO	Has to be reminded to attend to routine.
16.	YES	NO	Has frequent changes in mood.
17.	YES	NO	Makes distinctions between new and old personnel.
18.	YES	NO	Needs supervision on a job.
19.	YES	NO	Is sloppy.
20.	YES	NO	Mixes with other patients.
21.	YES	NO	Is constantly moving about.
22.	YES	NO	Takes part in back and forth conversation.
23.	YES	NO	Talks about his interests with attendant or nurse.
24.	YES	NO	Resents it if he is asked a question.
25.	YES	NO	Accepts hospital routine without complaint.
26.	YES	NO	His speech is very slow and drawn out.
27.	YES	NO	Sees things that are not there (visual hallucinations).
28.	YES	NO	Has to be reminded to follow routine.
29.	YES	NO	Answers sensibly if talked to.
30.	YES	NO	Expresses irrational ideas (delusions).
31.	YES	NO	Is slow in his movements.
32.	YES	NO	Has close friends on the ward.
33.	YES	NO	Yells at attendant when he is dissatisfied.
34.	YES	NO	Eats well.
35.	YES	NO	Is inclined to be shy.
36.	YES	NO	Responds to entertainment.
37.	YES	NO	Makes sexual passes at other patients or attendants.
38.	YES	NO	Talks volubly about many subjects.
39.	YES	NO	Keeps hair combed.
40.	YES	NO	Sits all day.
41.	YES	NO	Reads newspapers and magazines.
42.	YES	NO	Does any extra chore.
43.	YES	NO	Pays attention.
44.	YES	NO	Is neatly dressed.
45.	YES	NO	Takes part in ward games.
46.	YES	NO	Is making plans for when he leaves the hospital.
47.	YES	NO	Behaves well when taken off the ward.
48.	YES	NO	Knows the names of doctors, nurses and attendants.
49.	YES	NO	Admits that he is mentally ill.
50.	YES	NO	Knows who he is.

first month by the number of patients under observation during any first month (*i.e.* the total number in the sample). Similarly, a second-month proportion was determined by dividing the number of patients with that outcome during their second month of hospitalization by the number of patients under treatment for more than one month, etc. The computations were accomplished by first sorting the patients into groups of equal longevity starting with those who were still under treatment at the end of their year and ending with those whose hospitalization or treatment had lasted less than one month. Separate monthly proportions were computed for each type of outcome, and cumulative proportions were also determined so that it would be possible to see at the end of each monthly interval what had been the overall experience of each group up to that point in time.

Reliability was assessed from the first administration of the behavioral rating scale by an analysis of variance technique de-

TABLE 4

Mean Scores of Two Groups of Female Geriatric Patients on a Rating Scale for Ward Behavior

	N	Score on admission	Score after one month
Control Group	84	60.6	57.2
Geriatric Unit	92	59.6	65.6

TABLE 5

Comparison of Ward Behavior Ratings of Two Groups of Female Geriatric Patients Adjusted for Differences in Admission Status by Analysis of Covariance

	Total	Within	Between
1. Sum of cross-products:	17,548	17,891	−343
2. Sum of squares for follow-up ratings:	53,974	50,876	3,098
3. Sum of squares for admission rattings:	37,522	37,484	38
4. Degrees of freedom:	175	174	1
5. Correlation coefficient:	0.390	0.410	—
6. Degrees of freedom for r:	174	173	—
7. Regression coefficient:	0.46767	0.47730	—
8. Adjusted sum of squares for follow-up ratings:	45,767	−42,337	= 3,430
9. Degrees of freedom:	174	173	1
10. Mean squares*	—	245	3,430

* F corrected for admission status = 14.00; $p < .001$

scribed by Hoyt (1). This analysis yielded a reliability coefficient of .94 and a standard error for a score of 3.84 units.

Scores on the two ratings of ward behavior were compared for the 93 patients in the Geriatric Unit and the 83 control patients who remained under treatment at least one month.[3] Ratings for the patients' first week of hospitalization revealed no significant differences between mean scores of intensive treatment and control groups. In fact, the control group tended to be slightly higher than the intensive treatment group.

The follow-up ratings four weeks later suggested that the patients on intensive treatment had improved while the controls had declined. Table 4 presents the mean scores for the two groups.

An analysis of covariance was undertaken to test whether the two groups differed significantly at the end of the follow-up period when equated for the slight difference in initial level. The computations are summarized in Table 5. The results indicate that after correction for differences at time of admission, the intensive treatment group had improved significantly over the controls ($p < .001$).

These results do not identify the specific causes of change within the groups, but they do indicate that the benefits of the intensive treatment program were being reflected in the overt behavior of the treatment group. Had the gain been due merely to improved physical condition consequent on hospitalization, the control group might have been expected to show some improvement too instead of the slight decrement actually found.

Figure 1 is a bar graph which compares the outcome of treatment for the two groups at the end of one year. Patients were rated "improved" if they had shown any mobility during the observation year, that is, if they had had a significant release from hospital even if they had subsequently returned. Patients who had not been released at all during the year of observation were termed "unimproved." The number of deaths in each group is also shown. It will be noted that the proportion of deaths was greater for the controls (28.6 per cent) than for the treatment group (20.7 per cent). Of the treatment group, 50.5 per cent showed no improvement *vs.* 67.6 per cent for the controls. In the treatment group, 28.8 per cent made at least one move out of the hospital, as against 3.8 per cent of the control group. The disparity between the two groups on

[3] Eighteen patients from the Geriatric Unit and 22 controls could not be rated at the four-week follow-up because of death or transfer to surgical wards.

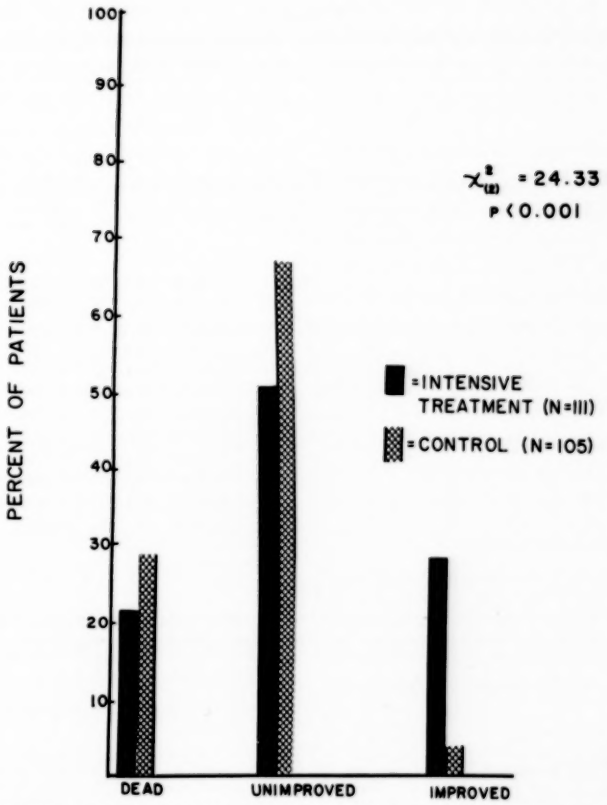

FIG. 1. One year follow-up of geriatric patients assigned to intensive treatment unit as compared with matched group in regular wards.

these outcomes is so great that the probability of its occurring by chance is only one in a thousand (chi-square with two degrees of freedom = 24.33).

Results of the actuarial analysis are presented in two tables, one for each group. Columns 1 through 5 of both tables record the actual counts of patients in the respective categories month by month. Columns 6 through 8 show the monthly proportions for each outcome. Columns 9 through 11 contain the corresponding cumulative proportions. As is customary in such tables, monthly proportions are symbolized by small letters (p_x = proportion left; q_x = proportion who died; r_x = proportion released), while the cumulative proportions are designated by capital letters (P_x = proportion of total left; Q_x = cumulative death rate; R_x = cumulative net release rate.) In Table 6 the intensive treatment group are distributed according to the various outcomes. Table 7 shows a similar distribution for the control group.

Inspection of Table 6, column 8 (monthly release rate), reveals that the Intensive Treatment Unit returned over five per cent of the patients to the community about a month after admission; accelerated its release rate to a maximum of 10 per cent by the fourth month; and then showed a gradual decline in release rate to one per cent by the end of the year. Column 11, which lists the cumulative release rates corrected for relapses, shows that 18 per cent of the patients were out of hospital after six months

TABLE 6

One-Year Follow-Up of a Cohort of Female Geriatric Patients Admitted to an Intensive Treatment Unit at Central Islip State Hospital (December, 1956 to December, 1957)

Months after admission	(1) No. under observation at beginning of mo.	(2) No. of returns during month	(3) Total to be accounted for dur. mo.	(4) No. of deaths during month	(5) No. released on convalescent care or family care during mo.	(6) p_x proportion of monthly accountables left at end of month	(7) q_x monthly death rate	(8) r_x monthly release rate	(9) P_x proportion of total cohort left	(10) Q_x Cum. death rate	(11) R_x Cum. net release rate
0–1	111	0	111	1	0	0.9910	0.0090	0.0000	0.9910	0.0090	0.0000
1–2	110	0	110	0	6	0.9455	0.0000	0.0545	0.9369	0.0090	0.0541
2–3	104	1	105	6	5	0.8953	0.0571	0.0476	0.8468	0.0631	0.0901
3–4	94	2	96	2	10	0.8750	0.0208	0.1042	0.7568	0.0811	0.1621
4–5	84	2	86	1	4	0.9419	0.0116	0.0465	0.7297	0.0901	0.1802
5–6	81	2	83	0	2	0.9759	0.0000	0.0241	0.7297	0.0901	0.1802
6–7	81	3	84	2	1	0.9643	0.0238	0.0119	0.7297	0.1081	0.1622
7–8	81	1	82	6	0	0.9268	0.0732	0.0000	0.6847	0.1622	0.1531
8–9	76	3	79	2	1	0.9620	0.0253	0.0127	0.6847	0.1802	0.1351
9–10	76	1	77	2	1	0.9610	0.0260	0.0130	0.6667	0.1982	0.1351
10–11	74	2	76	1	1	0.9736	0.0132	0.0132	0.6667	0.2072	0.1261
11–12	74	0	74	0	1	0.9865	0.0000	0.0135	0.6576	0.2072	0.1352

TABLE 7

One-Year Follow-Up of a Cohort of Female Geriatric Patients Admitted to Continued Treatment Services at Central Islip State Hospital (December, 1956 to December, 1957)

Months after Admission	(1) No. under observation at beginning of month	(2) No. of Returns during month	(3) Total to be accounted for during month	(4) No. of deaths during month	(5) No. released on convalescent care or family care during month	(6) p_x Proportion of monthly accountables left at end of month	(7) q_x monthly death rate	(8) r_x monthly release rate	(9) P_x proportion of total cohort left	(10) Q_x Cum. death rate	(11) R_x Cum. net release rate
0–1	105	0	105	5	1	0.9428	0.0476	0.0095	0.9428	0.0476	0.0095
1–2	99	0	99	9	0	0.9090	0.0909	0.0000	0.8571	0.1333	0.0095
2–3	90	0	90	3	0	0.9666	0.0333	0.0000	0.8285	0.1619	0.0095
3–4	87	0	87	1	0	0.9885	0.0114	0.0000	0.8190	0.1714	0.0095
4–5	86	0	86	0	0	1.0000	0.0000	0.0000	0.8190	0.1714	0.0095
5–6	86	0	86	2	1	0.9651	0.0232	0.0116	0.7904	0.1904	0.0190
6–7	83	0	83	1	0	0.9879	0.0120	0.0000	0.7809	0.2000	0.0190
7–8	82	0	82	2	1	0.9634	0.0243	0.0121	0.7523	0.2190	0.0285
8–9	79	0	79	3	0	0.9620	0.0379	0.0000	0.7238	0.2476	0.0285
9–10	76	0	76	2	0	0.9736	0.0263	0.0000	0.7047	0.2666	0.0285
10–11	74	0	74	0	1	0.9865	0.0000	0.0135	0.6952	0.2666	0.0381
11–12	73	0	73	2	0	0.9726	0.0274	0.0000	0.6762	0.2857	0.0381

and that 13.5 per cent were still out at the end of the year.

When the corresponding columns in Table 7 are examined for the Control Group, it is seen that the monthly release rate, column 8, was negligible and that the cumulative net release rate reached its maximum of 3.8 per cent only by the end of the year.

The monthly death rates, columns 7 and 11, also show an advantage for the Intensive Treatment Unit in addition to the difference in overall death rate reflected in Figure 1. Not only did fewer patients die in the Intensive Treatment Unit, but even the moribund tended to live longer. While over four per cent of the Control Group died within

their first month of hospitalization and another nine per cent in their second month; only six per cent of the Intensive Treatment Group had died by the end of the third month of hospitalization, while the maximum monthly death rate of seven per cent was not reached until the end of the eighth month.

SUMMARY

Biometric analyses were carried out for mobility and for changes in ward behavior of first admission female geriatric patients in intensive treatment and control groups in a state hospital. While the control patients were on regular services, which could do little more than provide physical care, the Intensive Treatment Unit offered these elderly patients psychotherapy, physiotherapy, occupational therapy, and placement services.

A rating scale was designed to measure behavioral symptoms of severity of illness observable by the ward nurse or attendant. The patients showed equivalent levels of adjustment at the time of assignment to their respective groups, but a significant difference in favor of the intensive treatment group was observed by the end of the first month.

A one-year follow-up revealed a significant advantage for the treatment group in releases and in number of deaths.

An actuarial evaluation of the various outcomes of treatment in the form of modified life tables combined experiences within each group of patients so as to provide month-by-month follow-ups. In this way it could be seen that the treated group had a higher release rate even when adjustments were made for returns; and, in addition to a lower death rate for the overall period, postponed the event of death even for the moribund.

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THE MORAL JUDGMENT OF SCHIZOPHRENICS[1]

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This is a report of an exploratory study of moral judgments made by schizophrenics. Three aspects of this research are reported: 1) differences in moral judgments made by schizophrenic patients and normal subjects, 2) the relationship of this difference, or extent of deviance, to the socio-psychological position of the subjects, and 3) the significance of moral judgments for value orientations.

There is a growing body of research evidence that whatever else schizophrenia may be, it is an impairment or disturbance of social understanding and participation. This view is emphasized in the theories of Sullivan (17), Cameron (9) and Arieti (3). More recently, experimental evidence supporting this view has appeared. Senf, Huston, and Cohen (15) found that schizophrenics were strikingly deficient in social comprehension as indicated by their impaired appreciation of humor. Whiteman's study (18) based on Cameron's ideas on the relationship between social disarticulation and thinking disorganization, showed that schizophrenics differed from normals on tests of social concepts to a greater extent than on formal tests. McGaughran and Moran (12) found that schizophrenic patients demonstrated a loss of social communication without evidence of impairment in abstractive ability.

An area within the realm of the social thinking of schizophrenics which has received little attention is that of morality or moral judgment, probably because of the association of morality with philosophy. However, morals are particularly important social-psychological phenomena in that they are the standards maintained by society to govern the action of its members. The ability to feel guilty, to be self-critical, or to behave responsibly is largely a matter of socialization and strongly reflects the extent to which the individual has been able to internalize the moral values of his society. Accepting and living by the moral standards of a social group implies harmonious involvement with the group and social deviants may be those individuals who do not know or do not accept a society's morals. According to Parsons (13), morality "concerns the state of the individual . . . with respect to his commitment to the values of society." Schizophrenics are considered deviant and often behave irresponsibly, however, whether they are simply lacking in value commitments or have commitments to deviant values is uncertain.

The problem of moral judgment of schizophrenics has been studied by Baruk and his associates (2, 4–7). Baruk devised a test of moral judgment which he called the "Tsedek Test," using a Hebraic word whose meaning combines the concept of charity with that of legal justice. Baruk reports that schizophrenic moral judgment is often impaired due to impaired ability to synthesize the various component parts of a complex social problem. The schizophrenic is indifferent to the need for arriving at a just solution and therefore often makes arbitrary, egotistical or incomplete solutions. Baruk referred to this as "affective indifference" or a "general diminution of feelings of humanity" (4).

[1] This report is based on a dissertation submitted to the Graduate School, University of Kansas, in partial fulfillment of the requirements for the Doctor of Philosophy. The author acknowledges the help and guidance of his dissertation committee, and especially thanks Drs. John W. Chotlos and M. Erik Wright. Thanks are also due to members of the psychiatric and psychological services of Winter VA Hospital, Topeka, Kansas and Kansas City, Mo. VA Hospital for their assistance in providing subjects for this study, and to Dr. Henri Baruk for permission to translate the Tsedek Test.

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While his research has revealed the importance of this area for the study of schizophrenia, his reported studies lack data on the extent of schizophrenic deviation, the types of moral judgments made, and as his research was with French subjects, it is not known how applicable his results would be for American subjects.

PROCEDURE

SUBJECTS

The experimental subjects were 45 schizophrenic patients and the control subjects were 15 nonschizophrenic general medical patients. The schizophrenic group was further divided into three subgroups of 15 patients each according to socio-psychological position. The phenomenon of withdrawal and the idea of a "retreat from society" suggested the following way of classifying the subjects. It is possible to conceive of four major positions in which a person might be with regard to social group belongingness: "in society" for the control group, "out of society" for the long term chronic schizophrenic group, "moving away from society" for recently hospitalized early schizophrenics, and "moving toward society" for chronic schizophrenics now ready for discharge from the hospital. "Society," in the sense used here, refers to the world of shared ideas, attitudes, beliefs, values and interests. A person is "in society" to the extent that he shares in this conventional frame of reference and is a responsible member of society at large. The groups could be classified more conventionally as nonschizophrenic, acute schizophrenic, chronic schizophrenic and schizophrenic in partial remission, but this study dealt primarily with social cognition and it seemed appropriate to compose the groups in a way that was as socially relevant as possible. The category "out of society," for example, is meant to include the group of individuals who presumably experience social isolation and alienation.

Patients were selected for the four groups according to the following criteria: *Early schizophrenics:* All had been hospitalized less than two weeks and had no history of hospitalization for treatment of a psychiatric disorder during the two years preceding the present admission. Some *Ss* in this group had been previously hospitalized, but in all cases, they had been discharged and were making a fair adjustment to nonhospital society, to the extent of being able to hold a job for at least part of the time they were out of the hospital. *Chronic schizophrenics:* Patients in this group had been hospitalized for at least two years prior to the experimental session, had achieved a fairly stable hospital adjustment as shown by a pattern of little change in symptoms and behavior from month to month, and were without plans for leaving the hospital. *Pre-discharge schizophrenics:* These patients were similar to the *Chronic* group in all respects except that they were being prepared for imminent discharge from the hospital. In the opinion of the staff, and with the consent of the patient, they were ready to leave the hospital either on a discharge basis or on trial visits. Most of the patients were preparing to return to their families, but some were going to foster homes. *Control group:* None of these patients had received a primary diagnosis for any psychiatric condition, all were hospitalized for a general medical condition or for physical rehabilitation, and were not acutely ill at the time of the experiment.

All subjects were white, male, hospitalized veterans between 20 to 60 years of age. Table 1 presents data for the ages, educational level, socioeconomic status, and kinds of schizophrenic reactions for the groups.

EXPERIMENTAL PROCEDURE

The basic procedure consisted of a semi-structured interview utilizing Baruk's *Tsedek Test of Moral Judgment* (7) with each story followed by sufficient additional inquiry, as in Piaget's studies (14), to make the sub-

TABLE 1

Mean Age, Mean Number of Years of Schooling, and Mean Socioeconomic Level of the Four Groups of Subjects

Group	Mean Age	Mean Years of Schooling	Mean Socioeconomic Level*	Type of Schizophrenia	
Normals	38.0	9.2	3.8		
Early schizophrenics	35.3	10.1	3.3	Paranoid	9
				Catatonic	2
				Hebephrenic	1
				Unclassified	3
Chronic schizophrenics	36.0	10.5	3.6	Paranoid	9
				Catatonic	2
				Hebephrenic	1
				Unclassified	3
Predischarge schizophrenics	35.4	10.6	3.9	Paranoid	11
				Catatonic	0
				Hebephrenic	1
				Unclassified	3

* Socioeconomic level scoring was based on criteria developed by Hollingshead and Redlich (11). Subjects were rated on a 5-point scale from 1 for Upper Class to 5 for Lower Class.

ject's answer clearly understood. Unelaborated answers, such as "that's all right" or "that's wrong," were not accepted as adequate responses. The possibility that *Ss* might fall into a response set of easy acceptance or rejection of the stories was eliminated by requiring that each response be justified. That is, the *S* was questioned until his reasons for agreeing or disagreeing with the stories were clearly understood. Examples of four of the fifteen Tsedek Test stories, as translated by the present writer, appear below:

1. In a barracks, a theft has been committed. It has not been possible to find the guilty person. However, the commander in charge of the barracks decides to punish one soldier out of every ten. What do you think of his decision?

6. During a period of restrictions, as during a war, the use of electricity is strictly prohibited. However, a frail and sickly young woman uses an electrical heater to warm herself. She is accused of stealing electricity and is immediately taken to prison. Do you think the punishment is justified?

7. A man learns that one of his enemies has just had an accident and is without help. The man refused to go to the help of his enemy saying that he wishes to get even with him. What do you think of his attitude?

8. A hospital is built in two sections: one is for the patients who are curable and the other is for those who are incurable. A lot of attention is given to the first and the second is neglected. What do you think of this idea?

The interviews were tape recorded and transcribed to provide verbatim records for analysis.

Two types of analysis were made; first, for conformity-deviancy and second, for types of value orientation. The Tsedek stories were designed to elicit judgments indicating either agreement or disagreement with the action in the story. Baruk's research with a paper and pencil form of the test showed that his normal Parisian subjects agreed very highly in rejecting the actions in the stories as "wrong," "unfair," or "unjust." In the present study, judgments of this type, disagreement, were scored as conforming and responses which indicated acceptance of the story action were scored as deviant. Responses in which no decision was made were also scored as deviant. Each S's deviancy score consisted of the total number of deviant responses to the fifteen Tsedek stories.

The question of value orientation required a survey of the total range of responses and depended mainly on the *S*'s stated reason for judging as he did on each story. The survey indicated that it was possible to classify the responses into the following seven types:

Humanitarian: Emphasis is placed on individual rights, freedom, equality, and relationships based on mutual respect. A

sympathetic concern is shown for the victimized or oppressed and human frailties are excused.

Authoritarian: Authority, obedience, and rules were regarded as more important than individual freedom, equality or relationships based on mutual respect.

Utilitarian: The larger social group and efficient functioning of social actions were regarded as more important than the rights and freedom of the individual.

Self-Protective: The subject declared it is better to protect oneself than to help others in need when a choice must be made.

Common-Practice: This is a judgment which declared that an act is right if it is something that seemingly occurs commonly in society, *e.g.*, "Everyone is doing it anyway, so I might as well, too."

Other: All judgments which did not fit the above categories were assigned to this category. This included responses too vague or irrelevant to be assigned elsewhere.

No Decision: If no decision was reached in response to a question it was assigned to this category.

As the Tsedek stories tended to elicit some kinds of deviant value judgments more often than others, it was not possible to classify a subject as, for example, more *Authoritarian* than *Utilitarian*. Only group differences could be analyzed.

Reliability of scoring was determined by randomly selecting a sample of 180 responses for rating by an independent judge. Agreement between the two judges was 95 per cent for ratings of deviancy and 88 per cent for ratings of type of value orientation.

RESULTS

As is shown in Table 2, the schizophrenic group as a whole gave responses judged to be deviant on 30.3 per cent of the Tsedek stories and the control group gave deviant responses on 4 per cent of the stories, a difference which was statistically significant at the .01 level. The test of significance of difference between the groups used throughout was the Median Test described by Siegel (16).

That the differences were due to group characteristics and not to the high deviancy of only a few group members was seen by examining the individual scores. Social conformity of response was quite marked in the control group. Seven subjects showed no deviancy, seven gave only one deviant response, and but a single subject gave two deviant responses. This pattern of homogeneity is in sharp contrast to the variability of the schizophrenics whose deviancy scores ranged from 0–13. Twenty-nine schizophrenics made two or more deviant responses, and only four gave no deviant responses.

The question as to the relation of deviancy of moral judgment to socio-psychological position was answered with the deviancy data described above. As may be seen in Table 2, the order of deviancy of the groups, from most to least was chronic, predischarge, early and control. This order suggests that a rather gross relationship does exist as the chronic group was con-

TABLE 2

Moral Judgment Deviancy

Group	N	Total Deviancy Score	Percentage Deviant Responses	No. of *Ss* with More Than One Deviant Response
Early schizophrenic	15	37	16.4	6
Chronic schizophrenic	15	94	41.4	12
Predischarge schizophrenic	15	74	32.8	11
Total schizophrenic	45	205	30.3	39
Control	15	9	4.0	1

Median Test Results

Total Schizophrenic > Control $X^2 = 8.56$	$p < 0.01$
Chronic > Control	$p < 0.001$
Predischarge > Control	$p < 0.001$
Early > Control	$p < 0.005$
Chronic > Early	$p < 0.01$
Chronic > Predischarge	NS
Predischarge > Early	NS

sidered most "out of society," and the control group most "in society" and the other two groups were considered to be intermediate. The greatest difference was between the control group which had a deviancy score of 9 and the chronic group which had a score of 94 ($p < .001$). Among the three schizophrenic groups, the only difference of significance was between the early and chronic groups, with the latter making more deviant judgments ($p < .01$).

As may be seen in Table 3, judgments of all types were made by the schizophrenics and the controls made all types except *Utilitarian* and *Other*. However, these two groups differed significantly in number of each type of judgment with the controls making more *Humanitarian* judgments ($p < .05$) and the schizophrenics more *Authoritarian* ($p < .001$), *Utilitarian* ($p < .01$), *Self-protective* ($p < .001$), *Common-practice* ($p < .02$), and *Other* ($p < .05$).

TABLE 3
Types of Moral Judgment

Type of Moral Judgment	Group				
	Early Schizophrenic	Chronic Schizophrenic	Predischarge Schizophrenic	Total Schizophrenic	Control
Humanitarian					
Total	181	121	148	450	217
Per cent	80.4	53.8	65.8	66.7	96.4
Authoritarian					
Total	12	24	23	59	5
Per cent	5.3	10.7	10.2	8.7	2.2
Utilitarian					
Total	6	17	10	33	0
Per cent	2.7	7.6	4.4	4.9	0
Self-Protective					
Total	15	26	34	75	1
Per cent	6.7	11.6	15.1	11.1	0.4
Common-Practice					
Total	5	6	5	16	1
Per cent	2.2	2.7	2.2	7.1	0.4
Other					
Total	0	14	3	17	0
Per cent	0	6.2	1.3	2.5	0
No Decision					
Total	6	10	2	18	1
Per cent	2.7	4.4	0.9	2.7	0.4

They did not differ significantly in giving *No Decision* responses.

As to the various subgroups, the controls differed from the chronic group in the same way as it differed from the total schizophrenic group. However, the magnitude of difference was consistently greater. The early group differed from the controls ($p < .005$). The predischarge group differed from the control group on these two types (both $p < .005$), and on *Utilitarian* ($p < .005$). Again, the only difference of significance between the schizophrenic subgroups was that the chronic group made more *Other* responses than the early group ($p < .025$).

DISCUSSION

MORAL JUDGMENT DEVIANCY

Baruk's results were essentially confirmed in that the controls of this study were much like his normal Parisians in consistently rejecting the story solutions as unjust; it thus seemed legitimate to regard the typical control group response as a "conforming" response.

The greater deviancy of the moral judgments of the schizophrenic patients is also consistent with other research into the social thinking of schizophrenics if deviancy is regarded simply as a kind of functional impairment. It seems particularly important that the controls made judgments that were so homogeneous, whereas the schizophrenics showed much more variability. This high intersubject agreement on the moral problems suggests that the control group members based their judgments on a common pattern of values, but that the schizophrenics did not base their judgments on quite the same core of values.

It is conceivable that subjects made deviant judgments because they did not understand the questions or because they were unable to communicate their understanding in a logical way, but this did not seem to be the most probable basis for the deviant

responses of the schizophrenics in this study. Examination of the protocols showed that while some of the schizophrenic responses were less coherent, logical, or relevant than those typical of the control group, this was not true for the majority of responses. No schizophrenic *S* made only deviant judgments and none gave uniformly incomprehensible responses.

SOCIO-PSYCHOLOGICAL POSITION AND DEVIANCY

A relationship was found to exist between socio-psychological position and moral judgment deviancy. The categories of "out of society" and "in society," as represented by the chronic schizophrenic and control groups respectively, seem to be meaningful and offer support for the "retreat from society" idea, but the relationship of these two groups to the other two groups is less clear. The relative similarity of the schizophrenic subgroups suggests they all more nearly represent "out of society" than "in society" positions. Nevertheless, the intermediate position of the predischarge schizophrenic group tended to be more like the chronic schizophrenic group and the early schizophrenic group tended to be more like the control group. These tendencies suggest that the predischarge group retains characteristics of the "out of society" position whereas the early schizophrenics still have ties to the "in society" position. This is reasonable in terms of their actual status; the predischarge group was selected for its resemblance to the chronic group in ways other than that its members were soon to leave the hospital. The early schizophrenics were selected on the basis that its members had been more or less normal until their recent hospitalization.

VALUE ORIENTATIONS

The values implicit in the judgments of the normals were predominantly of one kind, that which was termed *Humanitarian*. The following responses are typical:

T-1: "You shouldn't punish innocent people for something they didn't do."

T-8. "They both deserve care. They all have feelings and even if they're incurable they should be given a chance; at least made comfortable."

The attitude reflected in the judgments of normals included feelings of compassion, individual rights and concern for others beyond the self. These values were clearly evident in the moral judgments of the control *S*s.

The schizophrenics made *Humanitarian* judgments, but differed from normals in also making other types of judgments. Something of the moral orientations of the schizophrenic *S*s can be seen in the following brief, but fairly typical responses:

T-1. "Has to be done to bring discipline among the men."

T-6. "I think it's all right. Frail and sickly people can survive all right and don't require that consumption of power."

T-10. "I approve. You have to protect yourself before you protect somebody else. That's for sure. You have to look out for yourself first."

These moral judgments reveal a social ethic which is quite different from the humanitarian ethic evident in the normals' judgments, largely in being one of rejecting responsibility for the welfare of others. Through detachment, social relations are judged in terms of efficiency and orderliness instead of sympathy and compassion. People were viewed and judged as mere objects, hardly different from inanimate objects. The patients' passive acceptance of injustice also revealed their detachment.

An exaggerated concern for self-protection is also shown in some of these judgments. The importance of this attitude for the schizophrenic is emphasized by the fact that the judgments were made in a task setting where it would have been very easy to conceal real beliefs and conform to the socially acceptable *Humanitarian* judgment. The apparent belief of some of the schizo-

phrenics that is is "right" for a person to save himself at the expense of others apparently has two related aspects: a disregard for the other and a heightened concern for the self. Most writers (8–10) agree that the schizophrenic's self concern is one of great tenacity; it is a matter of life and death, and by comparison, all other concerns recede into insignificance. Two primary symptoms of acute schizophrenia, hallucinations and delusions, frequently center on the patient's own bodily organs and processes. The patient's own corporeal existence becomes the primary concern, and social values, such as helping another, must be rejected by him as much less important.

Other reasons for the greater number of nonhumanitarian judgments by the schizophrenics may perhaps be found in viewing their social situation. For example, emphasis on *Authoritarian* judgments may reflect their status as members with little power in hospital society. Authoritarian relationships are prevalent in hospitals and interpersonal relations tend to be coercive and operate through unilateral directions of power. Abel (1), studying subnormal girls, reached the conclusion that girls who were institutionalized in a constraining setting for the longest time, were most accepting of authoritarian attitudes. The findings of the present study were very similar. Among the schizophrenic *S*s, the chronic patients, perhaps most accepting of hospital constraints, made the greatest number of *Authoritarian* judgments, while the early group made the fewest.

Perhaps most important for our understanding of schizophrenia is that nearly all of the responses made by schizophrenics could be readily understood as reflecting some value orientation. Only the types of judgments called *Other* and *No Decision* showed no value orientation and these made up fewer than 6 per cent of all judgments. Of course, there was selectivity in the sample of schizophrenics interviewed, but in the opinion of the ward psychiatrist working with the patients they were typical of the patient population. The findings suggest that deviant schizophrenic moral judgments are not simply evidence of impairment, but represent value orientations which are at odds with those of the dominant social group.

None of the types of moral judgments or value orientations considered here is beyond the range of normal variation. Many "normal" people believe strongly in self-protection above all and in authoritarian and highly efficient human relations. Two points must be made; first, as the moral problems posed were simple, deviant responses are quite unusual and reflect extreme attitudes, and second, there is no reason to assume the schizophrenics are ever completely different from nonschizophrenics in social understanding. Thus, the attitudes which they showed in this study were those typical of tired, afraid, bitter and defeated men; but normal, albeit cynical men might well make similar judgments.

The Tsedek Test has some obvious technical shortcomings which should be corrected before using it in further research. A serious weakness is that the stories are constructed in such a way that the subject might answer in terms of a response set. This could be corrected by interspersing items for which a *Humanitarian* response would be assent rather than dissent. It would also be advantageous to broaden the range of social situations used in the stories to elicit a greater variety of value judgments.

SUMMARY AND CONCLUSIONS

Moral judgments made by schizophrenics were compared with those of nonschizophrenics in order to determine whether these groups differed in this area of social thinking. The groups studied were selected on the basis of their socio-psychological position, that is, a group of nonschizophrenics represented an "in society" position, a group of chronic schizophrenics represented an "out of society" position, newly hospi-

talized schizophrenics represented a "moving away from society" position and predischarge schizophrenics represented a "moving toward society" position. "Society," in the sense used here, referred to the world of shared ideas, attitudes, beliefs, values and interests.

There were 15 *Ss* in each group and groups were equated for age, education and socioeconomic status. The primary data consisted of responses of the *Ss* to a semi-structured interview based on Baruk's Tsedek Test.

1. Baruk's results with a written form of the Tsedek Test were essentially confirmed in the present study although an interview form was used

2. The results indicated that the moral judgments of the schizophrenics were significantly different from those of the non-schizophrenics; the difference was considered to be one of deviancy.

3. Deviancy of moral judgment was grossly related to sociopsychological position. The differential deviancy of the chronic schizophrenics and controls was in accord with their classification as "out of society" and "in society," respectively, but the other two groups, while occupying intermediate positions as expected, were nearer an "out of society" position.

4. Moral judgments reflect value orientations which are meaningfully related to psychological condition and social position. Normals made predominantly *Humanitarian* judgments, emphasizing values of justice, mutual respect and reciprocity in human relations, and sympathetic understanding. Schizophrenics emphasized *Humanitarian* values less and placed more importance on *Self-protective*, *Authoritarian*, *Utilitarian* and *Common-practice* values. These reflect tendencies toward social detachment, a mechanical view of interpersonal relations, egocentric self-concern and the influence of adapting to a constraining social environment.

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A NEW APPROACH TO INSIGHT: A PRELIMINARY REPORT[1]

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The concept of insight is a particularly vague one despite its frequent use by clinicians and theoreticians. A number of investigators have attempted to clarify the meaning of this concept, and a few have attempted to relate insight to other dimensions of personality (4, 7, 16, 20, 22, 25, 27). In general, however, these efforts have met with only limited success and there is still widespread confusion as to the meaning and significance of this concept in psychological theory and practice.

In view of the fact that the concept of insight occupies a major position in virtually all theories of psychotherapy, it is astounding that the literature contains so very few investigations in which insight has been systematically studied. For example, a perusal of the literature reveals only two experimental studies which attempted directly to explore the relationship between level of adjustment or severity of emotional disturbance and degree of insight. Shumsky (26) endeavored to determine whether schizophrenic and neurotic *Ss* differed in insight. Insight was defined as the amount of agreement between each patient's overt statements on a self-rating questionnaire and judges' ratings based upon the patient's projective test protocol. The investigator's basic hypothesis that schizophrenics will be more insightful than neurotics was not supported by his data.

Addressing herself specifically to the question as to whether psychological health is positively correlated with insight, Sweet (30) first devised a method for the measurement of insight in accordance with an operational definition. Three sets of observations were used: those relating to the self-percept, those pertaining to overt behavior, and those corresponding to covert motivational themes. Insight was defined in terms of the correspondence between the self-percept and overt behavior and between the self-percept and covert motivational themes, as determined by expert agreement in their categorization. Sweet (30) obtained positive relationships of moderate size between psychological health and insight into projected covert themes but found no significant correlation between psychological health and insight into overtly displayed actions. When indices of anxiety were used in place of ratings for estimating psychological health, there was no significant relationship with the insight indicators.

In both of these studies the criteria of insight were based on the correspondence between judges' ratings and the *Ss'* self-descriptions and were therefore subject to the customary limitations inherent in a method which relies upon judges' personality appraisals. The common denominator in the methods of measuring insight used in a number of other experimental studies (4, 5, 7, 9, 10, 11, 15, 16, 17, 25) also revolves around the determining of the extent to which the *S* sees himself as others see him. The evaluation of the degree of this congruence sometimes entails the actual observation of the *Ss'* behavior by trained observers, but more often depends upon group ratings by peers, upon inferences drawn from test results, or upon *Ss'* self-estimates as to how other people perceive them. An exception to this approach is that of Gross (14) who departed from the traditional method of measuring insight by using a measure of acceptance and admission of both the presence and absence of personal-

[1] A summary of this paper was presented at the Annual Meeting of the American Psychological Association, September, 1959, in Cincinnati, Ohio.

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ity traits when the acceptance runs counter to certain emotionally toned ideas or feelings of self-esteem. Eskey's (6) method also deviated from the usual pattern in that the criterion of insight was the verbal recognition by the patient of existing psychological difficulties.

The present study offers a different method and rationale for the measurement of insight in which the difficult task of accurately evaluating the *S*'s "true" personality characteristics is circumvented. The premise which the present method is based upon is that the ability to comprehend the causative factors underlying or determining general attitudes and behavior represents insight and that insight can be measured by determining the degree to which the *S* accurately interprets a number of hypothetical situations. An accurate interpretation requires that the *S* not be misled by manifestations which represent defensive maneuvers and that he be sensitively attuned to covert dynamics. This linking of insight to defensive reactions, it is believed, removes insight from the isolation of a poorly understood trait world and places it in a more dynamic, motivation-oriented context. Furthermore, the use of impersonal situations has the important advantage of permitting more objective determinations to be made of the most probable causative factors involved. For the purposes of this study, insight is therefore conceived of as lending itself to measurement on a continuum and also as intimately combining an understanding of others and of the self.

It is recognized that this definition of insight as encompassing the ability to understand impersonal hypothetical situations differs from the more common definition of the term which emphasizes awareness of one's own behavioral patterns and motivations. However, we suggest that an accurate understanding of oneself is largely dependent upon a realistic perception of the environment, and that conversely only a limited ability to comprehend others is possible if one possesses an inadequate understanding of one's own behavior and motivations. It is noteworthy that the intimate relationship between the understanding of the self and of others is given explicit recognition by those clinicians who regard personal psychotherapy as a necessary prerequisite for engaging in psychotherapeutic practice. Further research on the relationship between measures of self-understanding and of social understanding might provide more definitive evidence on this assumption.

PROCEDURE

DEVELOPMENT OF THE TECHNIQUE

A number of hypothetical situations were first formulated depicting the use of common defense mechanisms. For each situation, four explanatory statements were then developed and these choices were rank-ordered with regard to the degree of insight which they were thought to represent. The ratings were made independently by the investigators and three other judges who were unacquainted with the purposes of the study. Only situations on which agreement by four out of five psychologists was obtained were retained in the final form. The scale was then administered on a trial basis to a group of charge nurses and to college students who were asked to check, in each case, the choice which was indicative of the greatest amount of insight and the choice reflecting the least amount of insight. A fair degree of variability in performance was obtained even in some of the more psychiatrically sophisticated *S*s.

The form of the test[4] selected for further study included 27 different brief hypothetical situations; there are two situations for each of 13 different defense mechanisms and one situation in which a number of defenses are combined. The order in which the defenses appear has been varied systematically

[4] Copies of this test may be obtained without charge from the authors.

so that the same defense never occurs twice in succession. The following defenses are represented in the various test situations: denial, displacement, identification, introjection, isolation, compensation, projection, rationalization, reaction formation, regression, repression, sublimation, and undoing. Scoring is accomplished simply by totaling the number of times the *S*'s choice of most and least insightful explanation corresponds with the choices for each situation previously agreed upon by the psychologists.

The following examples taken from the test are presented to illustrate the types of hypothetical situations and explanatory statements which were devised.

A man who intensely dislikes a fellow worker goes out of his way to speak well of him.

1. The man really doesn't dislike his coworker.
2. The man believes he will make a better impression on others by speaking well of them.
3. The man is overdoing his praises in order to cover up for his real feelings of dislike.
4. The man doesn't want to hurt anyone's feelings.

A physician who has been suffering severe chest pains for many months is finally persuaded to go for a physical check-up. Although he is told that he has an incurable disease of his lungs, the physician carries on his work, making no plans for the future or that of his family.

1. The physician probably doesn't believe the diagnosis.
2. The physician probably hopes for a drastic change in his physical condition.
3. The physician doesn't want his family to become too dependent upon him.
4. The physician doesn't want to admit the seriousness of his illness.

The first example describes an instance in which reaction formation is used as a defense. All five judges regarded the third alternative as representing the most insightful explanatory statement and the first choice as indicating the least insight. In the other example, denial is the defense mechanism being illustrated with all judges agreeing that the fourth and third choices represent the most and least insightful answers, respectively.

RELIABILITY

A test-retest coefficient of .855 was obtained after a one-week interval for 27 college students in an introductory course in psychology at the University of Bridgeport in Connecticut. This suggests that the Insight Test is adequate in reliability.

VALIDITY OF THE INSIGHT TEST

After the test had been developed in its present form, its validity was determined by comparing test scores obtained by patients with independent insight ratings made on each of these patients by their psychiatrists and by psychologists who had tested these patients. The patients on whom the validation studies were performed were drawn from a sample of adult hospitalized and clinic patients at the Institute of Living. Thirty-nine male and 29 female *S*s were included. In intelligence, the 44 patients on whom some intellectual estimate could be obtained range from 81 to 134, with a mean of 110.9. The age range is 17 to 67 years, the mean being 35.7. A variety of neuropsychiatric disorders are represented among the 63 patients on whom a formal diagnosis is available: there are 20 schizophrenics, 16 neurotics, 15 personality disorders, five patients with disorders caused by organic impairment, and seven patients with functional psychoses other than schizophrenia.

Since all patients were not rated by both a psychiatrist and a psychologist, the comparisons are on different groups of patients. The ratings were made on a 5-point scale ranging from "significantly below average for most patients" to "significantly above

average for most patients." An effort was made to obtain ratings reflecting the patient's insight status at the time the Insight Test was administered. The judges were given the following definition of insight in an attempt to anchor the concept to the same meaning which determined the construction of the test. "Insight is the extent to which an individual comprehends the causative factors underlying or determining feelings, attitudes and behavior. Insight is conceived of as lending itself to measurement on some sort of continuum and also as intimately combining an understanding of others and the self."

Twenty-three resident and staff psychiatrists participated in the ratings of 68 psychiatric patients. Patients receiving ratings of 1 and 2 were grouped together as were those with ratings of 4 and 5; patients who were rated 3 constituted the third group. Table 1 shows that when t tests are computed for the three groups taken two at a time, the comparison between the two groups falling at the extremes of the rating scale, *i.e.*, those patients rated 1 and 2 as compared with those rated 4 and 5, is significant ($t = 2.16$) at the .05 level. The mean insight test scores are 27.9, 30.2 and 36.3 for the low, average and high insight groups, respectively.

A similar analysis was completed on Insight Test scores of 32 patients who were grouped according to the insight ratings assigned to them by three psychologists. As shown in Table 2, comparisons of the three groups considered in pairs yields one significant difference at the .02 level ($t = 2.78$), namely, the comparison between the two groups at the extremes of the insight continuum. The group rated as above average in insight had a mean insight test score of 36.1. The below average group's mean was 27.3, while the middle group obtained a mean of 32.6. These findings indicate that psychiatrists' and psychologists' judgments of patients' insight are significantly related to Insight Test scores.

The distribution in Table 3 presents information on the accuracy of prediction which may be obtained, with psychiatric ratings as criteria, using different cut-off scores on the test. For example, an Insight Test score of 30 or above includes 90 per

TABLE 1

Comparison of Insight Test Scores of Three Groups of Patients Formed on the Basis of Psychiatric Ratings of Degree of Insight*

Comparison	t	p
Groups 1 and 2 *vs.* Groups 4 and 5	2.16	0.05
Groups 1 and 2 *vs.* Group 3	0.78	n.s.
Groups 4 and 5 *vs.* Group 3	1.82	n.s.

* Groups 1 and 2 consist of patients rated below average, groups 4 and 5 consist of patients rated above average, and group 3 represents patients rated average in insight.

TABLE 2

Comparison of Insight Test Scores of Three Groups of Patients Formed on the Basis of Psychologists' Ratings of Degree of Insight*

Comparison	t	p
Groups 1 and 2 *vs.* Groups 4 and 5	2.78	0.02
Groups 1 and 2 *vs.* Group 3	1.68	n.s.
Groups 4 and 5 *vs.* Group 3	1.56	n.s.

* Groups 1 and 2 consist of patients rated below average, groups 4 and 5 consist of patients rated above average, and group 3 represents patients rated average in insight.

TABLE 3

Cumulative Distribution of Insight Test Scores for Patients Falling at the Extremes in Independent Psychiatric Judgments of Insight

Insight Test Scores	"Low" Insight Cases Psychiatrically Identified (Ratings 1 and 2)		"High" Insight Cases Psychiatrically Identified (Ratings 4 and 5)	
		%		%
20	9	26	0	0
25	14	40	1	10
30	16	46	1	10
35	22	63	4	40
40	34	97	6	60
45	34	97	10	100
46 and above	35	100	10	100

cent of all patients considered to be high in insight by their psychiatrists. However, only 46 per cent of those rated low in insight would be identified with this cut-off score. Increasing the insight score to 40 permits one to identify 97 per cent of the patients rated low in insight but produces a 60 per cent false negative rate in the identification of those high in insight. It is evident that while this test permits differentiation between groups of patients having varying degrees of insight, the differences are too small for use in making individual predictions.

EFFECT OF DIAGNOSTIC CATEGORY ON VALIDITY

Although the validation data previously presented indicate that psychiatric patients who are rated above average in insight by psychologists or psychiatrists tend to differ significantly in their test scores from those rated below average, the question remains as to whether these differences are not a function of estimated differences in type of pathology rather than differences in insight. It is conceivable that the judges were actually basing their insight ratings on the diagnostic impression of patients. In order to shed some light on this problem, an analysis was made of the relationship between psychiatric and psychological ratings of degree of insight and the diagnoses of the patients being rated. This analysis was made only on patients who could be dichotomized into the neurotic or psychotic classification and excluded a relatively large number of cases who obtained an average insight rating by psychiatrists or psychologists. The chi-square test presented in Table 4 reveals an absence of any significant association between insight ratings of psychiatrists and diagnostic category. When the degree of association between psychologists' insight ratings and diagnostic category is computed, a chi-square of .23 is obtained which is also insignificant. These findings suggest that insight ratings and type of psychopathology were unrelated. Consequently, the assumption that the judges based their insight ratings on factors other than kind of disease seems to be justified.

It is also noteworthy that when 64 patients, exclusive of those with an organic brain injury, are dichotomized into neurotic and psychotic classifications, no significant differences (t = .90) are obtained between the neurotic and psychotic patients in Insight Test scores.

TABLE 4

Degree of Association between Psychiatric Insight Ratings and Diagnoses of 41 Patients

Diagnoses	Psychiatric Ratings	
	Low Insight (Ratings 1 and 2)	High Insigh (Ratings 4 and 5)
Psychotic	16	4
Neurotic	15	6

Chi-square = 0.08, n.s.

EFFECT OF INTELLIGENCE ON CRITERION

Even though it can be demonstrated that insight ratings are not contaminated by the variable of diagnostic category, it is still possible that the test criterion is affected by the patients' level of intellectual functioning. In order to check on this possibility, a chi-square test was done to determine the degree of association between psychiatric insight ratings and intelligence. As can be seen in Table 5, this analysis results in a chi-square of 3.66 which is not significant. Similarly, the degree of association between psychological insight ratings and intelligence is also insignificant (chi-square = 4.08, $p < .20$).

RELATION BETWEEN TEST SCORES AND OTHER VARIABLES

INTELLIGENCE AND INSIGHT

Some effort to investigate the relationship between insight and intelligence was made, since our definition of insight implies that

some intellectual capacities are involved in insightful behavior. Holt's (16) work also suggests that intelligence may play an important role in certain measures of insight and projection. Unfortunately, however, formal intellectual evaluations were available only on some of our *Ss*, and even in these instances they were based sometimes on abbreviated forms of the Wechsler Adult Intelligence Scale, rather than on the complete scale. Accordingly, only an approximate measure of the degree of association between intelligence and Insight Test scores was possible for 44 *Ss*. Table 6 indicates that there is a significant degree of association between intelligence and insight scores. It is suggested that an attempt be made in future studies to ascertain the exact relationship between these two variables and to partial out the effect of intelligence on insight scores.

TABLE 5

Degree of Association Between Psychiatric Insight Ratings and Intelligence

Psychiatric Ratings	Intelligence		
	Below median	Above median	Total
High insight (Ratings 4 and 5)	1	5	6
Average insight (Rating 3)	10	6	16
Low insight (Ratings 1 and 2)	11	11	22
	22	22	44

Median intelligence = 111.
Chi-square = 3.66, 2 d.f., $p < 0.20$.

TABLE 6

Degree of Association Between Intelligence and Insight Test Scores

Insight Score	Intelligence (IQ)					
	80–89	90–109	110–119	120–129	130 & above	Total
Below median	1	17	1	3	0	22
Above median	0	3	10	6	3	22
	1	20	11	9	3	44

Median insight test score = 32.
Chi-square = 22.16, 5 d.f., $p < 0.001$.

AGE AND INSIGHT

The product-moment correlation between age and insight, using 56 neuropsychiatric patients, is $-.282$. Although this r is significant at the .05 level, it is of very small magnitude with a coefficient of alienation of .959 and therefore does not seem to be of predictive importance.

SEX AND INSIGHT

When 56 patients are separated by sex and a comparison of their Insight Test scores are made, no significant differences are obtained. The mean insight score for the 29 males is 29.41, and for the 27 female patients 28.26, yielding a t of .40.

COMPARISON BETWEEN PSYCHIATRIC PATIENTS AND NON-PATIENTS

It is sometimes asserted that insight is a necessary condition for a healthy personal adjustment even though there is fairly widespread acceptance of the belief in some circles (8, 12, 13, 31) that some of the most seriously disturbed patients, especially schizophrenics, display a surprising degree of insight into their own, into other patients', and even into their therapists' behavior. In general, however, the consensus of opinion appears to be that there is a positive relationship between insight and adjustment (21, 24, 28, 29). In this part of the study an attempt was made to ascertain whether the Insight Test could discriminate between groups of normals and psychiatric patients.

METHOD AND SAMPLES

Three groups of *Ss* were compared with one another on the Insight Test, two at a time; one group was composed of 56 neuropsychiatric patients drawn from the sample described previously; one consisted of 115 untrained nurses; and one was composed of

106 trained psychiatric nurses. The Insight Test was administered to the patients individually as part of the battery of psychological tests but was group-administered to the normal *S*s.

The 115 female nurses who were tested prior to their psychiatric nursing training, and the 106 female student nurses tested following the completion of at least part of their training, ranged in age from 18 to 31 years, the median being 20 years. The age differences between student nurses and patients are significant. Although there were no measures of intelligence available on these student nurses, normative data on psychiatric nurses in general (2) strongly suggests that these student nurses did not differ significantly from the patients in overall intellectual capacity. For example, Carini (2) found a mean IQ range extending from 105.6 to 112.5 for five groups of nursing students coming from five representative mental hospitals in the State of New York. The mean IQ for the five groups was 109.6 which is virtually the same as the mean of our patients on whom quotients were available or could be approximated. Since the intelligence distribution for patients did not seem to differ significantly from the one estimated for student nurses, it was not deemed necessary to control for intelligence in comparing these two groups with one another.

TABLE 7

Comparison of Patients, Untrained Student Nurses and Trained Student Nurses on Insight Test Scores

Comparison	t	p
Patients and Untrained Nurses	3.14*	0.01
Patients and Trained Nurses	4.76†	0.001
Untrained and Trained Nurses	3.08	0.01

* Cochran and Cox modified t at the 0.01 level is 2.69.

† Cochran and Cox modified t at the 0.001 level is 3.45.

RESULTS

When the untrained group is compared with the trained group of nurses there is no significant difference in variances. However, the means, 33.70 for the untrained and 36.14 for the trained nurses, differ at the $<.01$ level. In comparing the trained and untrained nurse groups with patients, the variances differ significantly, being larger for patients. Therefore, the Cochran and Cox (3) modification of the t test was applied to determine whether the means also differed significantly. It was found that the patients' mean of 28.86 is significantly ($p < .01$) lower than that of the untrained nurses; the patients' mean is also significantly ($p < .001$) lower than that of the trained nurses. Table 7 presents the various t values and levels of significance.

GROUP DIFFERENCES AS RELATED TO AN EXTREME LACK OF INSIGHT

It was assumed that when reversals in choices occur on the Insight Test, *i.e.*, when a *S* selects as the most insightful answer one which is assigned to the least insightful category by the judges or, conversely, when a *S* regards as least insightful an answer thought by our judges to be reflective of the greatest insight, this would represent an extreme lack of insight into the given situation. Comparisons of groups for mean number of reversals reveals a mean of 3.14 for 56 patients, 2.14 for 58 untrained nurses, and 1.38 for 50 trained nurses. These results indicate that while reversals occur relatively infrequently, they do appear more often in patients than controls. In order to ascertain whether these differences are statistically significant, t tests were done, comparing two groups at a time. Since there were significant differences in group variances, the Cochran and Cox (3) modification was used. The results presented in Table 8 indicate that the t test ($t = 3.20$) between patients and trained nurses is significant at the .01 level but that the other comparisons fail to attain significance.

EFFECT OF TRAINING

The significant difference between all trained and all untrained student nurses suggested that training can play an important ancillary role in determining level of insight, as measured by this technique. In order to evaluate the specific contribution of training, a group of 56 student nurses was tested at the beginning and at the completion of an intensive 3-month training course in psychiatric nursing. Included in this program were references to and specific illustrations of the use of common defense mechanisms and their meaning. The mean insight score for this group increased from 33.43 to 36.04, yielding a t of 3.43 which is significant beyond the .01 level. The test-retest correlation was .542, indicating that the group insight pattern remained relatively stable.

TABLE 8

Comparison of Patients, Untrained Student Nurses and Trained Student Nurses on Number of Reversals

Comparison	t	p
Patients and Untrained Nurses	1.64*	n.s.
Patients and Trained Nurses	3.20†	0.01
Untrained and Trained Nurses	1.72‡	n.s.

* Cochran and Cox modified t at the 0.05 level is 2.00.

† Cochran and Cox modified t at the 0.01 level is 2.70.

‡ Cochran and Cox modified t at the 0.05 level is 2.69.

DISCUSSION

This novel method for measuring insight is demonstrated to have some validity, as it is significantly related to independent psychiatric and psychological judgments of patients' insight. Since the criterion itself is far from being perfectly reliable, the validity as obtained by this method can be taken to represent a lower value than it would be with a more reliable criterion. Furthermore, the discriminative ability of this test can doubtlessly be enhanced by selecting only those items which have the greatest predictive value and eliminating others. The authors are currently engaged in an item analysis in order to refine the method, hoping eventually to substitute items of greater discriminating value for those that rank low in this respect. The inherent high interest value which this technique possesses for even the most seriously disturbed patients appears to constitute one of its greatest assets.

It is encouraging to note that the test does not represent a measure of kind of pathology, since there is no significant relationship between Insight Test scores and diagnoses, but represents something apart from pathology. This is consistent with Shumsky's (26) observation that the neurotic-schizophrenic dimension is independent of the patient's degree of insight. The finding that the psychiatrists and psychologists did not consciously or unconsciously react to the diagnostic implications in making their insight ratings serves to strengthen the impression that the criterion used here was not confounded by the variable of type of pathology.

Not only is this brief test successful in differentiating between groups of more and less insightful *S*s, but it also discriminates significantly between psychiatric patients and non-patients. This finding is considered extremely important since there is so little available definitive data on the relationship ship between psychological health and insight. Assuming that the test is a reasonably valid instrument, this finding would then lend support to the hypothesis that psychiatric patients on the whole do have less insight than non-patients. Such an hypothesis conforms to "common sense" expectations, but has never been subjected to rigorous experimental test.

Future research could be directed at the question of whether various nosological groups demonstrate any consistent differences in overall insight. In addition, the

relationship between lack of insight into specific defense mechanisms and the tendency to utilize these mechanisms could easily be investigated. The hypothesis to be tested would state that *S*s favoring the use of certain defenses have relatively little insight into these same mechanisms. In this connection it is noteworthy that the nature of the relationship between insight and other defenses, such as projection and distortion, has received only scant attention by researchers in the past. Holt (16) found a +.50 correlation between projection and insight despite the commonly held view that projection is antithetical to insight. Another finding was that a positive relationship exists between low self insight or low social insight and distortion in rating others. The relationship between insight and projection was also investigated in a study by Fabian (7). He found no evidence of a positive relationship between low self insight or low social insight and projection. There was even some evidence suggesting a positive relationship between high self insight or high social insight and projecting in rating others on certain traits. One might conclude from these studies that the issue is by no means settled and that some revision in our customary conception of the relationship between insight and defense mechanisms might be necessary.

A simple way of verifying some theoretical conceptions of the prevalence of specific defense mechanisms in various psychopathological conditions would also be available. For example, patients representing the supposed extremes on the projection-introjection continuum, namely, paranoids and depressed patients, could be tested with this instrument. The paranoid patients might be expected to show less insight into the defense of projection compared to depressed patients and, conversely, the latter would be expected to show less insight into the defense of introjecting than the former. Other predictions, based on the presumed preference for certain defenses by various types of patients, could be made for compulsive, hysteric, and other diagnostic groups.

The test might also be used to determine the relationship between effectiveness of therapy and insight. Whether the attainment of insight as a result of psychotherapy is a necessary condition for recovery from mental disease is a controversial problem although, in general, most clinicians stress the vital importance of uncovering repressed material in order to enable the person to function in a more uninhibited and realistic manner (1, 18, 19, 23, 32). It is therefore assumed that improvement will be associated with increased insight. However, Kelman and Parloff's (17) conclusions that group therapy with neurotics did not lead to any substantial changes in either of the two self-awareness measures used, indicates that much research still needs to be done in this area. The Insight Test described in the present paper might facilitate such research.

The present study suggests that insight, as measured here, can to some degree at least be affected by training in psychiatric subject matter but that the effect of training is less than the patient or non-patient status of the *S*. Since the psychiatric training of student nurses, involving both exposure to a psychiatric climate and didactic procedures, represents not only the acquisition of new information but is probably accompanied by significant emotional changes as well, it is not surprising that such training affects insight scores. If one conceives of psychotherapy as a learning situation in which the individual is made more sensitive to the causative factors underlying his behavior patterns, then one might expect the test scores of the patients to reflect the effect of this "training in insight." The fact that the patients still scored significantly lower on the Insight Test than either of the two control groups underscores their relative deficiency of insight compared with normals. The finding that new experiences as well as intelligence per se contribute to what we mean by insight supports the assumption

that insight is dependent upon cognitive functions as well as emotional factors. It also focusses attention on the need to control these variables when this test is used. It is proposed further that like-aged groups be used in future research with this test since there is a slight but significant negative correlation between age and insight scores. As mentioned previously, the precise effect of intelligence on insight scores requires further study.

SUMMARY

This study proposed a novel method, based on a different rationale from the ones previously used, for the measurement of insight. With the use of a new test, which requires the individual to interpret a number of hypothetical situations in which common defense mechanisms can easily mislead the *S* in his interpretations, it is possible to circumvent the previously necessary but very difficult assessment of the *S*'s "true" personality as compared with his self-evaluations.

The development of the Insight Test is described and data on its reliability and validity are presented. Validation studies were conducted on 68 patients by using as criteria psychiatric and psychological judgments of insight. It was found that these ratings were independent of diagnostic impressions and of patients' intellectual status and that they were significantly related to test scores. The relationship is not large enough, however, to permit individual predictions.

Test scores show a significant association with intelligence, correlate slightly ($r = -.282$) with age, and are unrelated to sexual status. Psychiatric patients are found to be significantly ($p = <.01$ and $<.001$) less insightful on this test than two control groups. Training also affects insight scores to a significant degree, suggesting that cognitive factors contribute to the overall measure, but is secondary to degree of adjustment.

The technique appears especially suitable for the investigation of specific hypotheses related to changes in insight accompanying psychotherapy, for studies of the relationship between degree of insight into certain defense mechanisms and frequency of their use, and for investigations of the relationship between nosological classifications and insight. The test is currently in the process of being further refined through item analysis in the hope that an even more discriminating measure might be developed.

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THE SELF-HELP ORGANIZATION IN THE MENTAL HEALTH FIELD: RECOVERY, INC., A CASE STUDY[1]

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The past decade has witnessed the growth of a relatively new form of activity in the mental health field: the self-help group of former mental patients. Forty-two such groups are currently in existence, the majority established in the past five years. The largest and perhaps the oldest of these groups is Recovery, Incorporated: The Association of Nervous and Former Mental Patients. Recovery reports over 1,800 dues-paying members, and a total regular attendance of over 4,000 individuals. It officially recognizes 250 local groups in 20 states, located mainly in Illinois and Michigan. Other self-help groups in the mental health field tend to be small and have relatively short life-spans, while Recovery has exhibited a significant growth. However, despite this growth, Recovery has as yet failed to make any perceivable impact upon professionals in the mental health field. Prior to this report, no extensive study of the structure, functioning, and therapeutic potential of this organization has been attempted.

For the purposes of this study, information about Recovery was obtained from a number of available sources:

1. The Recovery literature.
2. Visits to various groups by the author, and four consultants.
3. A questionnaire study of the membership.
4. A questionnaire survey of psychiatrists' opinions about Recovery.

[1] This report is based upon a study conducted as a special project of the Joint Commission on Mental Illness and Health under a grant from the National Institute of Mental Health. The author wishes to thank Jack R. Ewalt, M.D., Director of the Commission, Fillmore H. Sanford, Ph.D., and Greer Williams for their help in the execution of the study. He is also grateful to various members of the Task Force on Patterns of Patient Care for their advice and counsel, particularly to Charlotte G. Schwartz, M.A., associate director, and Morris S. Schwartz, Ph.D., task force director.

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HISTORICAL DEVELOPMENT

Recovery was founded in 1937 by the late Abraham A. Low, M.D., a neuropsychiatrist on the faculty of the University of Illinois College of Medicine. Originally, the organization was limited to patients at the Psychiatric Institute of the University. In 1942, the organization and the Institute severed connections, and Recovery secured private offices in Chicago. Under Dr. Low's leadership, Recovery acquired a specific method of self-help and after-care aimed at the prevention of relapses and chronicity among the mentally ill. Group meetings were conducted as part of Low's treatment procedure, and Recovery members were drawn mainly from patients in his private practice.

During the early days of the organization, Low kept in close contact with the activities of the groups. He received regular reports from the leaders, and personally attended the larger discussions at which he presented the final interpretations of the subject matter. Gradually, as the organization grew in size, Low's direct control over group activities of necessity decreased. Finally, in 1952, he withdrew his objections to the expansion of Recovery on a national level, in effect placing the direct control of the widely scattered local groups in the hands of his former patients who had become group leaders. With Low's death in 1954, the transition of Recovery from a professionally supervised adjunct to psychotherapy to a lay-run form of self-help became complete.

Recovery is incorporated under the laws

of Illinois as a non-profit organization, and is financed through annual membership dues, the sale of literature and records, and individual "good will" donations. The national headquarters of Recovery, Inc., is located in Chicago. The organization is run by a Board of Directors, a councilors committee, and organizational officers. The councilors and directors are elected annually by the dues-paying members, and the officers are appointed by the Board of Directors. There are no formal criteria for membership, other than that of being a former mental patient or "nervous person." Essentially then, any individual who perceives himself to be emotionally disturbed may join. Furthermore, an individual may start a new group if, in addition to qualifying for membership, he studies the Recovery method, receives at least one week's formal leadership training, and obtains authorization from the Board of Directors.

THE RECOVERY METHOD

Recovery utilizes exclusively the techniques, principles, and terminology described in its official text, *Mental Health Through Will-Training* (3). The member is expected to read this book, learn Dr. Low's system, utilize the system in his everyday life, and obtain practice in its application by attending weekly group meetings. The book does not present an overall systematic formulation of a theory of mental health, but rather each chapter is intended to illustrate one or more principles through the use of examples.

In order to present most accurately the Recovery method, it was necessary to outline its major basic assumptions and concepts. In each case, the reader is referred to the page in the textbook where a more complete statement may be found. The following analysis is not intended to serve as an exhaustive treatment of the system, or as a detailed statement of the official Recovery position, but rather as a way to acquaint the reader with the essence of the method. The method will be presented without any attempt to evaluate the validity of its assumptions or the effectiveness of its techniques. These points which follow will be discussed in a later section.

1. The returned mental patient and the psychoneurotic both suffer from similar symptoms (3, p. 18).
2. The psychoneurotic or postpsychotic symptom is distressing but not dangerous (3, p. 112).
3. Tenseness intensifies and sustains the symptom; and thus should be avoided (3, p. 135).
4. The psychoneurotic and postpsychotic patient are particularly susceptible to the arousal of tenseness because of their excessive irritability (3, pp. 86, 88).
5. The use of free will is the basis of the Recovery method and the solution to the nervous patient's dilemma.
   (a) The life of the individual is governed by free will (3, p. 185).
   (b) The psychoneurotic or postpsychotic patient can attain mental health through the use of his will (3, p. 19, p. 145, p. 209).
   (c) The function of the will is to accept or reject thoughts or impulses (3, p. 132).
6. Mental health should be the supreme goal for the mental or nervous patient (3, p. 384).
7. The "physician" is the supreme authority on all matters pertaining to mental health (3, p. 24).

In summary, these assumptions state that when the physician diagnoses a condition of a psychoneurotic or postpsychotic patient as a nervous symptom, the patient should realize that, although the condition is distressing, it is not dangerous. The patient should accept the diagnosis of the physician, and should attempt to employ his will in order to eliminate the tenseness which sustains and intensifies the symptom.

The situation is to be restructured in terms of the following Recovery principles, and the individual is to act within this new cognitive framework:

1. *Spotting:* When a symptom, impulse or thought appears, it must be "spotted" for what it is. The individual must see that there is no danger involved. Spotting is a form of introspective relabeling of various components of the situation.

2. *The Recovery Language:* When an individual restructures the situation, he must employ the basic tool of the method, the Recovery Language. The use of Recovery Language is intended to change a situation from one that is felt to be beyond the control of the individual to one that can be coped with.

3. *Differentiation between External and Internal Environment:* An individual's life space is composed of the external and internal environment. The external environment consists of the "realities" of the situation, and can seldom be changed. The internal environment consists of various "subjective" components, such as feelings, thoughts, impulses and sensations. These can be controlled, restructured or reappraised.

4. *Avoidance of Judgments of "Right" or "Wrong":* For any given life situation, an evaluation of "right" or "wrong" is merely an opinion, or a subjective judgment. The Recovery member should refrain from making such evaluations as they serve only to produce temper, which in turn increases tenseness and contributes to symptoms.

5. *The Average versus The Exceptional:* The member should consider himself to be an average person, and should strive to be average. He should realize that his symptoms are no worse than anyone else's symptoms, that he is no sicker than anyone else. Each situation is average as it has been and will be encountered by numerous other individuals.

Once the situation has been restructured in accordance with these principles, it remains for the individual to act. Recovery guide lines for action can be characterized broadly by the term *control*. In essence, the individual is told to control those aspects of his internal environment which serve to propagate tenseness. The primary condition that is to be controlled is *temper*. Two types of temper exist: fear and anger. Temper is a combination of feelings with an evaluation that the self or the other person is "right" or "wrong." The individual is to control temper, to reject and suppress thoughts and impulses which result in tenseness. He is to force himself to bear the discomfort of doing that which he fears. In situations which are not dangerous, the individual must act despite the subjective anguish which his symptoms may be expressing.

The individual must constantly *endorse* himself for each effort at the practice of Recovery, no matter how minute. Self-endorsement is a basic principle of Recovery. It is a way in which the member can congratulate himself, not necessarily because he was successful, but because he tried to utilize the method. Low believed that, eventually, each effort will entail less work; each attempt will be more successful. The restructuring of the situation will become automatic and will require little or no conscious application. With each success, the individual's self-esteem will be increased, and he will eventually come to believe what he has been told: that he can, through the use of his will, achieve mental health.

THE RECOVERY GROUP MEETING

At the present time, meetings of Recovery groups are intended to serve the purpose of providing members with the opportunity to practice the techniques of Recovery. Groups are usually composed of between 11 and 30 members. Meetings follow a rigid schedule in order to assure conformity with the methods and beliefs of Recovery. It is the leader's function to guide the meeting

along the pre-arranged format. Each meeting is divided into four parts.

1. Reading from the Textbook.

The first part of the meeting is usually devoted to the reading of a chapter from the textbook. The leader may call on members to read short paragraphs. A technique widely used in some groups is to call on members who are hesitant about reading in public. This may serve the function of encouraging newcomers to join in the activities of the group. At the conclusion of his paragraph, the reader is quite often asked whether he had any symptoms during the reading. He is then "endorsed" for having the "will to bear discomfort," the "courage to make mistakes," and for being "group minded" by doing what he "feared to do." Thus at the same time that the newcomer is encouraged to participate in the meeting, he is also given a practical demonstration of the Recovery method at work in reference to his own reading. This is frequently an important first step in motivating the curious newcomer to become a Recovery member. The most obvious purpose of the readings is to expose the members to the contents of the book, and to encourage them to continue the reading at home. Sometimes one of Dr. Low's records or tape-recordings is substituted for the readings. This portion of the meeting usually lasts for 30 to 45 minutes.

2. The Presentation of Examples.

Rules for Presentation: The leader introduces this portion of the meeting by stating that only members who have read Dr. Low's book may participate. Newer members who as yet have not read the book are asked to listen quietly, and to save their questions and remarks for the question period. The participants form the "panel" and are usually seated face-to-face around a table.

The leader informs the group that all examples have to be taken from "trivial" everyday occurrences, and, since Recovery is a lay-run non-medical organization, it cannot help individuals with major problems. This is often qualified by stating Dr. Low's belief that such "trivial" incidents comprise the bulk of a nervous patient's problems. The leader then asks one of the members to read a portion of the official outline (4) for the presentation of an example. The outline divides each example into four parts:

a. A detailed description of an event.
b. Description of the symptoms and discomfort that the event aroused.
c. Description of the utilization of Recovery principles to cope with the event.
d. Description of the reaction which the member would have experienced before joining Recovery.

The Nature of the Examples: As a result of the rigorous regulations for the presentation of panel examples, there is very little variation as to the type of examples given at the meetings. In addition to the actual rules, the "model" examples included in Low's book also serve to set the tone for the members' examples. In general, the examples presented at Recovery meetings may be characterized by:

a. *Familiarity.* Only commonplace everyday events are usually discussed. The events have usually taken place in the very recent past.

b. *Concreteness.* Very literal, extensive descriptions of these events are given. Specific times, places, and individuals are usually mentioned.

c. *Uniformity of Symptoms.* The same symptoms are usually mentioned by most of the panel participants. These symptoms are almost always identical to the symptoms cited in the textbook. It is as if the textbook is used as a basic symptom list, from which members may choose the symptoms most appropriate for them.

d. *Somatization of Symptoms.* In addition to the uniformity in the symptoms, there is a tendency to present symptoms in somatic terms. This, too, is probably influenced by the type of examples discussed in the text-

book. The most frequent types of symptoms discussed are: air hunger, heart palpitations, perspiration, and tremors.

e. *Exclusive Use of Recovery Concepts.* In nearly all cases, examples are presented in terms of Recovery language. If an occasional term such as "projection" or "identification" is introduced, it is soon withdrawn by the speaker.

f. *The Testimonal.* The majority of examples serve as testimonials, since they refer to the success obtained through the use of the Recovery method as compared to the failures encountered previously. Success is not a prerequisite for the presentation of an example, since an individual is to be endorsed for each attempt in the use of the method regardless of its result. However, the form in which all examples must be constructed is conducive to the presentation of testimonials. Occasionally unsuccessful examples are also given, but they are in the minority.

3. Group Participation.

After the speaker has finished giving an example, the meeting is thrown open for comments from the panel. This is called "group spotting" and involves an analysis of the example through the use of Recovery concepts. The leader usually starts the discussion and calls upon volunteers. Comments must be phrased in Recovery language, and must pertain to the example under consideration. The leader immediately stops any discussion not in accordance with this rule. Comments may be classified as either positive or negative in nature. Positive comments are usually predominant, and consist of enumerations of the Recovery principles that were utilized by the person who gave the example. The leader praises him for utilizing these principles. Some negative comments are also included, consisting mainly of instances in which the individual failed to apply certain Recovery techniques. The individual who has given the example is free to accept or reject the comments and criticisms of the panel. The tendency is for him to accept all comments, and to agree with the group. In cases when negative comments are made, the group congratulates the individual for the Recovery methods utilized, and for being able to present an example not fully successful in nature. In addition, the individual is told not to attempt to be too perfectionistic by always expecting total success. Thus, both successful and unsuccessful examples are praised. The tendency is not to permit any example to pass, regardless of how successful the narrator may have thought it was, without adding additional Recovery concepts that may be applied to it. In this way, the panel is constantly reminded that no one can practice Recovery perfectly, and that everyone can always learn more, and benefit from practice before the group.

4. The Question and Answer Period.

At the conclusion of the panel presentations, there is a brief question and answer period, which usually lasts no longer than 15 minutes. Anyone may ask questions about the examples that were presented. Newcomers are particularly urged to participate. Comments must be limited to the examples, and at no time may one question the Recovery method itself, except to obtain clarification of a term or concept. No discussion of other psychological theories or systems is permitted. If a new member brings up a possible disagreement between the Recovery system and what his doctor may have told him, he is quickly told that the panel is not qualified to discuss such an issue since it does not relate to the example.

5. The "Mutual Aid" Social Meeting.

Nearly all the members remain after the formal part of the meeting has been concluded. Refreshments are usually served, and individual members may talk to each other and to the leader. The designation of this period as "mutual aid" refers to the fact that this is an opportunity to discuss problems and to obtain advice from others.

There is an attempt to keep this informal discussion within the bounds of the Recovery method, and to utilize only the techniques and concepts of Recovery, Inc. A rule of thumb is that all discussions of problems should be limited to five minutes, so as not to leave time for self-pity and complaining. During this part of the meeting the leader and the veteran members usually speak to newcomers in order to interest them in Recovery.

Recovery provides an additional mechanism through which a member may obtain help from other members during a time when no meetings are being held. A member who is experiencing difficulties may telephone a veteran member or leader. The problem must be presented and discussed in the same way as any panel example.

THE RECOVERY MEMBERSHIP

In order to obtain information about the personal characteristics of the Recovery members, questionnaires were sent to the Chicago headquarters and to the state leader in Michigan, to be distributed to the members. Of the 1,875 questionnaires that were distributed, 779 were completed and returned. The answers seemed to present a rather clear picture of the typical Recovery respondent, although general interpretations should be made with some caution. Since there was no control over the distribution of the questionnaires, and since it cannot be assumed that the non-responders would have answered in the same way as the respondents, the characterization which follows may not apply to the entire Recovery membership. It does, however, describe in general terms at least 779 members.

Background Factors. The modal Recovery respondent appears to be a middle-class, middle-aged, married woman. She has had at least some high school education, and may have attended college. Her husband is employed in a non-manual occupation and the yearly family income is approximately $6,000.

The typical Recovery respondent has one or more dependent children. She is active in community and church affairs, belongs to one or more voluntary community associations, and attends church services weekly. She takes part in various leisure time activities, *e.g.*, hobbies, and visits or entertains her family, friends, and neighbors. Thus she is an individual who appears to be integrated into her community and who, at least on the basis of certain socio-economic criteria, appears to hold an average or perhaps better-than-average status.

Reasons for Joining Recovery. Most of the respondents had originally learned about Recovery in the lay press, and had joined at the suggestion of a relative or friend. Only about a tenth of the respondents stated that they had joined on the advice of a physician.

The respondents reported that they entered this activity because they believed that they had one or more symptoms usually associated with a nervous or mental disorder. The major reasons for joining were given as follows:

a) psychological symptoms, such as fears, delusions, and "nerves";
b) psychosomatic symptoms, such as tremors and heart palpitations;
c) curiosity about whether the organization could help.

History of Hospitalization and Treatment. The respondents reported relatively few extensive histories of treatment for nervous or mental disorders prior to joining Recovery. Half of the respondents reported no hospitalization, and about one-fifth reported no professional treatment of any kind before joining Recovery. Among the respondents who reported hospitalization, there was little indication of chronicity, since the majority indicated very few hospitalizations, and of very short duration.

Extent of Participation in Recovery. For most of the respondents, Recovery appears to be a regular and long-term activity. Such obligations of membership as regular attendance and participation in the panels are con-

scientiously fulfilled. It is apparent from statements made by these individuals that membership in Recovery is treated as a vital, significant activity.

Approximately one-third of the respondents had been in Recovery for less than one year, one-third for one to two years, and one-third for three years or more. Almost all of the respondents reported that they attended meetings weekly. The length of membership, high frequency of attendance and high level of participation are of interest in view of the observation that over a third of those answering the questionnaire stated that they no longer need to attend meetings in order to function adequately.

The Special Case of the Leader. Of the 779 questionnaires, 112 were returned by leaders or assistant leaders of local Recovery groups. In general, the leaders displayed the same characteristics as regular members, with only a few minor exceptions. Leaders tended to be of a slightly higher socio-economic level. They reported more activity in church and community groups, and they displayed slightly more extensive histories of previous treatment for nervous or mental disorders.

THE ROLE OF THE MEMBER

The distinctive philosophy and method of Recovery facilitates establishing a particular type of role for the member. The first aspect of this role relates to the fact that the individual is a member of a group which meets regularly in order to provide mutual aid. Each member has certain obligations toward his fellow members and in return has certain expectations about their behavior toward him. He is expected to show concern about the condition and progress of other members, to provide them with support and acceptance, and to help them in the "correct" application of the Recovery method. He has expectations that others will act toward him in a similar manner. Because of the mutual aid quality of Recovery, the group feels helped by any individual's successes or harmed by any individual's failures.

By joining Recovery, the participant formally admits to himself and to others that he is "a nervous patient," and that he is formally associating himself with a group of nervous and former mental patients. The individual is to view himself, and in turn is to be viewed by others, within the context provided by membership in such an organization.

The term "nervous patient" may be a strange one to apply to the members of an organization completely lay run and directed, since "patient" usually implies treatment by a physician or other professional. However, the Recovery members do refer to themselves at meetings as "patients," and can be said to assume the nervous patient role. Of itself this role has a number of implications.

The Recovery Nervous Patient Role is Voluntary. Adopting the nervous patient role is completely voluntary: the individual has the choice of joining or not joining. For some people this may be merely a formalization of a role status which has already been in existence. Such individuals may have formerly been hospitalized, or may have previously been under treatment for a nervous or mental disorder. Through the utilization of various mental health facilities, they may have already identified themselves as nervous patients. However, according to data obtained with the questionnaire survey, a sizable segment of the Recovery membership has had no contact with such mental health facilities. For these individuals, the act of joining Recovery seems to imply a voluntary acceptance of a role that may be highly devalued in contemporary American society, and a consequent exposure to the stigma that is often associated with this role.

The Recovery Nervous Patient Role is an Acceptance of "Difference." Membership in any specialized group may result in the perception of the self as different from individuals who do not belong to the group. In certain groups, the feeling of difference may be extremely vague and unstructured, but in

Recovery the theoretical framework is seen specifically to outline the nature of the difference. The member is told that he is different from the average person in that he is more prone to the development of tenseness, and that he cannot tolerate as much tenseness as the average person. Thus, the Recovery member is cautioned to control and avoid actions which may be completely permissible to the average person.

The Recovery Nervous Patient Role is an Acceptance of "Similarity". At the same time that the Recovery member may accept the assertion that he is different from other "healthy" individuals in the community, he may be also impressed with the fact that he is similar to the nervous patients within Recovery. The Recovery method stresses that all nervous patients are "average," and that no nervous patient is sicker than any other nervous patient. The members are thus provided with an in-group which experiences the same problems, practices the same method, and utilizes the same terminology.

The Recovery Nervous Patient Role Provides a Cognitive Framework from Which the Individual Must View His Actions. The Recovery member must evaluate his actions from the point of view that he is a nervous patient. He must not exhibit temper, because he is told that this will increase his symptomatology. He must carefully judge all of his behavior in relation to what bearing it will have on his mental health. Thus, when the Recovery member is shoved in the subway or caught in a traffic jam, he must act according to Recovery principles, even if it means inhibiting a spontaneous reaction.

The Recovery Nervous Patient Role is Generalized to All Aspects of Life. Since a member must apply the Recovery method to all phases of his life, particularly to all trivial, routine, everyday occurrences, the nervous patient role assumes *maximal generalization*. The role is not limited to the individual's behavior within Recovery, but pervades all spheres of his activity: his job situation, his home life and his recreational pursuits.

Participation in Recovery Serves to Reinforce the Nervous Patient Role. The nervous patient role is constantly reinforced through membership in Recovery. The repeated application of the method serves to reinforce the role, as does the perception of success in utilizing the method. Even partial failure in applying the method may serve to reinforce the role, as the individual may feel that he has more to learn, and must try harder. Secondary rewards such as group support, recognition, and encouragement may also serve to reinforce the Recovery nervous patient role.

No Formal Mechanism Exists for the Termination of the Recovery Nervous Patient Role. Low required patients to attend classes and meetings for at least six months. He did not set any general termination date for membership, but it can be assumed that this was managed on an individual basis. Currently there is no one to suggest to a member that he is ready to end his membership and to surrender the nervous patient role. In view of the fact that one of Recovery's major aims is expansion, it would seem very unlikely that anyone would be urged to leave. Secondary gain may be sufficient motivation for many individuals to remain in Recovery, even though continuation of the nervous patient role may no longer be necessary. Barring the operation of other factors, there appears to be an in-built tendency within Recovery for long-term continuation of membership.

THE SPECIAL ROLE OF THE LEADER

Like the member, the group leader assumes the role of a nervous patient through the act of belonging to Recovery and through the utilization of its method. In order to participate in panel meetings an individual must give examples concerning his own problems and symptoms. Leaders are not exempt from this, and in fact usually present numerous examples in order to keep the meeting active. The role of the leader,

however, has certain additional features which deserve comment.

The Leader as an Expert. Perhaps the major function of the leader is to serve as an expert in the utilization of the Recovery method. Leaders are perceived by the group to be sophisticated in the use of Recovery terminology and concepts. Because of their position, they are able to control the agenda and content of the meeting, and serve as the major interpreters of the method. Most leaders stress that the Recovery method is not open to interpretation, and must be employed as it is written. However, a leader's comments at the panel meeting are usually more highly valued by the group than those of any other individual.

The Leader as a Guardian of the Method. The leader may control the meeting by deciding whether an issue under discussion is in accordance with Recovery regulations. A leader may terminate comments which he considers not pertinent to the example under discussion. A leader's decision in such matters is almost always considered final, and is seldom challenged. To be sure, any interpretations or decisions on the part of a leader may be brought to question by the group. Individual leaders determine for themselves how strongly they may wish to utilize their authority, some being more permissive than others. Since membership in Recovery is voluntary, leaders must allow the group certain degrees of freedom in order to motivate members to remain in the group. A completely authoritarian leader might alienate his members through arbitrary decisions and actions.

The Leader as a Role Model. Recovery leaders tend to be viewed by the members as possible models for their own behavior. The role model qualities of the leader may not only include his knowledge of Recovery techniques, but also his behavior during the social part of the meeting, as well as his general level of "health." Although leaders may not be necessarily any "healthier" than the members, they may be perceived to be freer from difficulties, and their behavior may be emulated. The type of panel examples that the leaders present often influences the type of examples presented by the group. In this way the apparent level of mental health of a leader may set the tone for his group. For example, in one group a leader was observed to present examples that did not reflect severe problems and difficulties. This appeared to influence the group in such a way that almost all examples presented were of the same general type. In other groups where leaders spoke of very severe psychological difficulties, examples given by members were of the same order.

BASIC FUNCTIONS OF RECOVERY

Undoubtedly Recovery helps to satisfy some of the needs of its members; otherwise it would cease to exist. In response to the questionnaire survey, almost all of the members indicated satisfaction with the organization. They reported that they had been helped, and were particularly enthusiastic about the group aspects of Recovery.

The functions the organization may serve for its members may be separated into two major categories: the functions of the Recovery method, and the group functions of Recovery.

BASIC FUNCTIONS OF THE RECOVERY METHOD

Ordering the Psychological Field as a Means of Reducing Anxiety. The Recovery method is characterized by a search for order amidst a labyrinth of complex psychological problems and processes. Personal experiences are restructured within the cognitive framework provided by Recovery so that events which may be anxiety-promoting and unfamiliar may be translated into a more familiar and understandable form. Examples are presented in such a way that complex psychological problems tend to be treated as tangible symptoms of a somatic nature. Since examples must be about trivial incidents, they tend in the main to entail familiar everyday experiences. Symptoms

appear to become standardized, and somaticized, almost exclusively adhering to the type cited in the textbook. In this manner a degree of certainty is introduced into the psychological realm, since even the most threatening emotions may be viewed as conforming to a set of universal regulations.

In addition members are given a simple routine to counteract the anxiety-producing uncertainty associated with their problems. This is done by imposing a rigidly standardized procedure characterized by repetitiveness. The meetings assume the characteristics of ritual and may serve to reduce anxiety in the same manner as the ritualistic ceremonies described by Malinowski (5) in his study of primitive religions. Each member is provided with a set of simple semantic labels to be used as tools for restructuring subjective experiences. The tools are available to all and may be manipulated with relative ease, once the Recovery method has been learned.

Introduction of Controls to Strengthen Defenses Against Anxiety. The basic component of the Recovery method is the belief that an individual can and must exercise control and self-discipline in all matters that affect his mental health. The will is to be trained to achieve this desired end through the continuous application of Recovery techniques. It is as if an attempt is made to strengthen the defense mechanisms of the Recovery member and to provide him with new controls and defenses against anxiety. Control is to be first introduced at the simplest and most basic level. The individual must learn to walk when he is tempted to run, to lie down when he is agitated, to make decisions in the simplest situations. Eventually, control is to be extended to the more complex processes, such as the suppression of temper and the rejection of anxiety-producing impulses. Self-discipline is to be gradually generalized to all spheres and levels of activity. The Recovery meetings themselves assume the characteristics of exercises in self control. Impulses to speak must be checked. The individual must first raise his hand and must make his comments in accordance with the strict procedural regulations.

Inspiration and the Power of Positive Thinking. The continuous reporting of successful examples at Recovery meetings may provide inspiration for the members. If one hears that other members are successfully coping with their problems, he may begin to believe that he too can do the same. In line with the inspirational aspects of Recovery meetings is the stress upon what may be designated as "the power of positive thinking." The member is constantly told to employ positive thoughts and to reject negative ones. The Recovery theory is presented in such a way that all psychological difficulties appear to be manageable. It is almost as if the nurturing of positive thought is believed to lead to positive results.

This aspect of Recovery resembles a once-popular form of psychotherapy based on auto-suggestion, devised by Emile Coué. In effect, the members are to tell themselves that "every day I get better and better." It is hoped that such auto-suggestion will lead to actual success in the elimination and suppression of symptoms. However, there appears to be a basic contradiction which may affect the operation of this form of positive thinking. The Recovery member is not only told to have positive thoughts, but he is also told that he *must* have them because is a nervous patient and can only afford to have positive thoughts. All positive thoughts, therefore, are based on the assumption that the person is a nervous patient. The acceptance and maintenance of this basic assumption may keep the self-fulfilling prophecy from operating.

Maintenance of Activity and Satisfaction of Dependency Needs. Recovery on the one hand implies a passive acceptance of the authority of the founder of the method and, on the other hand, the belief that mental health can only be attained through active effort. Recovery requires that the members accept the authority of Dr. Low, as em-

bodied in his writings and their presentation by the leader of the group. The new member passively puts himself in the hands of Recovery, forming a dependent type of relationship with the leaders, the members, and the basic authority of Dr. Low's text. In return, he is given a method and told what to do. Through the acceptance of the group's authority, the newcomer may obtain gratification of his basic dependency needs. He may feel that if he obeys the rules and regulations of Recovery, he will be taken care of.

However, counteracting this trend toward dependency and passivity is the stress in Recovery upon self-help. The Recovery method must be actively practiced. The member is told that progress can only come through continual effort and work. The individual can receive help from others, but in the long run it is his own effort which will produce progress. The combination of the passive dependency and active self-help elements in Recovery may serve to fulfill the individual's dependency needs without lulling him into passive inactivity. Salvation in Recovery may be obtained only through work, but the work must be done along the lines prescribed by the organization and by Dr. Low.

Cathartic Value of the Recovery Confessional. The group confessional aspects of the meetings may aid the individual in removing some of the anxiety associated with his symptoms. The mere act of publicly admitting the symptom may serve to disassociate some of the affect with which the symptom is labeled. Guilt and stigma associated with the attempt to hide the presence of symptomatology may be eliminated. Getting the symptom "off one's chest" may provide at least temporary relief. In addition, when one individual confesses his symptoms, others may learn that the symptoms which they have are similar.

The Semi-Religious Nature of Recovery. The Recovery method and its practice at panel meetings is clearly reminiscent of various elements characteristic of certain organized religions. The method involves faith and acceptance of regulations handed down by a higher authority. The method stresses self-discipline and the volitional aspects of human nature. This type of approach is more amenable to certain religious beliefs than is the Freudian and Darwinian notion of man as an instinct-driven animal. The emphasis on the power of positive thinking and on inspiration is also clearly analogous to some religious tenets.

The analogy between Recovery and religion may be extended further. Recovery has a bible, the textbook of Dr. Low. Hero worship of Low sometimes assumes the proportions of making him almost appear a god-figure. The leaders assume the role of disciples. In certain Recovery groups, the desire for expansion and for national recognition is analogous to the missionary zeal in religious groups. In addition, the repetitive ritual-like panel meetings resemble certain forms of religious ceremonies.

THE GROUP FUNCTIONS OF RECOVERY

Current organizational policy is to de-emphasize the social nature of the organization and to concentrate on the method. However, the importance of the group atmosphere is not neglected. Members take part in extracurricular social activities such as outings and parties. A social period of "mutual-aid" has become institutionalized as part of every meeting. Individuals come to meetings early and remain until the late hours of the evening to spend additional time with their fellow members.

Membership in Recovery involves more than the practice of a particular method of self-help and aftercare. It also entails membership within a community of individuals who have joined together because of perceived mutual problems and goals. Members form interpersonal relationships with one another, are affected by and in turn affect each other. The Recovery method serves to increase the solidarity of the group. The uniqueness of the Recovery language allows

it to serve as a badge of membership which can be used to distinguish the in-group member from the outsider. The agreement upon basic goals also serves to strengthen group feeling.

The Recovery group provides the individual with significant others with whom he may interact. For the social isolate this, in itself, would constitute an important motive for membership. For the members who have other opportunities to interact in the community, certain special aspects of the Recovery group setting may be particularly attractive.

Recovery as a Sheltered Social Environment. Recovery differs from other types of organizations because of its distinctive composition and general goals. All members are perceived to be in need of help, and are encouraged to discuss their symptoms freely. No one is stigmatized for having psychological problems. The members need not conceal the nature of their difficulties in order to obtain group acceptance. It is almost as if Recovery provides its members with a sheltered social environment in which everyone is treated as being equal, despite the level of his mental health or the nature of his symptomatology.

The Recovery group exhibits a greater tolerance for deviant behavior than other organizations. Individuals are generally accepted by their peers despite behavior that might be considered abnormal in other groups, as long as these persons adhere to the basic regulations of Recovery. The overall atmosphere is supportive, since members have joined together to help each other. Within such a group environment, the person whose concern over his symptoms might have previously interfered with his social interaction may find it easier to relate to other group members. He may also be able to test various patterns of behavior, and to abandon those which are inappropriate.

The individual may learn that other people are confronted with similar difficulties and problems. In this way, he may change his previous perceptions of his particular situation as unique. He may identify with other members of the group, and lose the feeling of isolation and sense of stigma imposed upon him by his symptomatology.

The Group as a Source of Secondary Rewards. Inherent within the Recovery framework is a formal reward system designed to motivate participation at the meetings. Individuals are to be endorsed for reading from the textbook, for presenting examples, and for appropriate comments and questions. The reward system covers almost all behavior that goes on during the meeting. If an individual is not as yet able to present an example, he may be endorsed for not feeling forced to give one, or for just listening. As a consequence, the mere presence of an individual at a meeting warrants some form of endorsement. Continuous endorsement is intended to raise the level of self-esteem of the members. Besides the formal reward system, the individual obtains other rewards in exchange for his membership. He is provided with a social group which will accept him, and give him support and recognition. These social rewards are not contingent upon the degree of success or improvement that may be obtained through the method. To be sure, apparent successful utilization of the method may result in a higher level of social reward, but a certain amount accrues to all members.

It may be that the social rewards which had previously served as a means to an end, have become functionally autonomous, and may serve as ends themselves. A member may join to receive help for his particular difficulties, but because of the social rewards may remain in the organization even if he has not obtained sufficient help to alleviate his symptoms, or if he has obtained enough help to be able to function adequately without further attendance at meetings.

The Group as a Controller of Behavior. The group may serve to control behavior through the manipulation of rewards and sanctions. Control is applied primarily to assuring con-

formity to the doctrines of Recovery. Thus, the individual must use the accepted vocabulary, must provide appropriate examples, and must conform to the various regulations. The group socializes each member. He must learn to control his impulses by speaking only after raising his hand. He must refrain from autistic verbalization which could prevent him from utilizing the method appropriately. He must sit still when not participating, so that he does not disrupt the meeting. If his behavior is anti-social he is a threat to the group and must be controlled. Very few sanctions are applied by the group, but perhaps the simplest and most effective one is to ignore completely the non-conformer. If he does not adhere to the method, his comments are cut off by the leader and his remarks are ignored by the group.

Recovery as a Cause. In many local groups there is the tendency for Recovery to be a cause in itself. The member may not only identify with his fellow group members, but also with all Recovery members. This act of identification may extend the person's ego boundaries in such a way that the success or failure of the organization is perceived as the success or failure of the self. The member becomes totally involved in the organization, and serves as a missionary whose desire it is to convert the non-believing world to Recovery's cause. Identification with Recovery may enable the individual to transcend his immediate problems and difficulties. Recovery becomes a cause to be preached to all who will listen. In this way, the individual may remove a great quantity of libidinal energy from his symptoms and utilize it in missionary activities. This zeal can take many directions. It may be used to build up Recovery membership and to gain national recognition for the organization. It may also be employed to foster anti-professional attitudes, and to foster the belief that it is "Recovery against the world." The exact nature that this may take depends upon the individual and the climate of opinion in his group.

POTENTIAL PROBLEMS ARISING FROM MEMBERSHIP IN RECOVERY

Although Recovery is the largest self-help group in the mental health field, its membership comprises only a small segment of the potential number of former mental patients and emotionally disturbed individuals. Alcoholics Anonymous, founded at the same time as Recovery, reports that in 1956 it had 5,000 groups in 60 countries with a total membership of 150,000 (2). In addition, while A.A. has received widespread professional and lay recognition for its efforts, Recovery has yet failed to do so. Although the problems of alcoholism and mental illness may not be similar, the differences between the two self-help organizations may be indicative of certain limitations of the Recovery approach.

When a survey of opinions about Recovery was made among members of the American Psychiatric Association in Detroit and Chicago, certain important qualifications concerning the effectiveness of the organization became apparent.

In general, the psychiatrists felt that Recovery is a helpful and valuable tool because of its group aspects. They felt that the group meetings satisfy the needs of some ex-patients for various forms of group support. However, they were concerned that the organization is not under medical or professional supervision, and that there is no systematic screening of members and no thorough selection and training of leaders. Some psychiatrists were particularly wary of the particular method that Recovery utilizes. Criticisms of the method included statements like the following.

1) It offers magical-omnipotent-authoritarian-unrealistic solutions.
2) It is superficial, limited and prevents or hinders insight.
3) It is regressive, fixes defenses, forces adjustment at a low level of maturity.
4) It creates complacency about the problem of mental illness.

These criticisms illuminate two major potential problem areas in the functioning of Recovery: problems relating to the absence of professional supervision, and problems arising from the Recovery method itself.

PROBLEMS RELATING TO THE ABSENCE OF A PROFESSIONAL

The transition of Recovery from an adjunct to the treatment regimen of Dr. Low to a lay-run self-help organization has left a number of unresolved problems. The Recovery method specifies that the physician is the primary authority in all matters pertaining to mental health. Only he is qualified to make a diagnosis, and the patient must follow his directions if he is to get well. At present, there is no physician associated with Recovery. As a consequence, certain functions that may have previously been fulfilled by Dr. Low now are either relegated to the lay leaders or no longer performed.

Selection of Members. At present, the Recovery method is to be used by all the members, regardless of the specific nature of their disorders. Originally, members were mainly patients of Dr. Low. It may safely be assumed that he had some control over their selection. Current Recovery membership, of course, includes many people who were never treated by Dr. Low, and some who have never received any professional treatment for psychiatric disorders. There is real doubt as to whether the method is appropriate for all of these individuals.

Recovery, it should be remembered, is a voluntary organization, and participants are free to leave at any time. An individual who feels that he is not receiving adequate help, or that he is being harmed, will probably drop out. However, it is possible that secondary social rewards stemming from membership in the group may motivate some persons to continue as members even if the Recovery method is inappropriate for them.

Selection of Leaders. Recovery also has no formal criteria for the selection of leaders. In view of the crucial position of the leader within the organization, this may constitute one of the organization's greatest weaknesses. When the founder was guiding the activities of the Recovery groups, he was in the position to exercise a strong influence in leader selection. At present anyone may become a leader if he takes the short-term training course and gains the approval of the Board of Directors. Thus, there is the real possibility that mentally ill persons may become leaders and may manipulate the group in accordance with their own needs. This is a high order of potential danger since the leader may serve as a role model for the behavior of others.

Leaders, however, must present examples about their own personal problems and difficulties. They must be able to operate in a group, and must be sufficiently fluent verbally to utilize the method. These requirements may eliminate certain types of mentally ill individuals from leadership roles. In addition, since Recovery is a voluntary organization, the leader must be able to motivate the members to remain in the group. Although these factors may serve as partial safeguards against poor and unhealthy leadership, they by no means eliminate the danger completely.

"Graduation" Policy. Recovery does not have any specific policy for the "graduation" of its members. When Dr. Low was present, he may well have advised certain members that they no longer needed to attend meetings. Without this type of advice, members may remain in the organization after they no longer need to, or when they are not receiving sufficient help from it. Many individuals who have been in the organization for three years or more still attend meetings frequently. Others still attend meetings regularly despite feeling that they no longer need to. Because Recovery is in a state of expansion and desires to build up its membership, it is highly unlikely that any member will be asked to leave, even when such a course would be beneficial to him. Of course, for certain individuals, continued member-

ship, perhaps even on a lifetime basis, may be instrumental in the obtainment of necessary support.

Control over the Contents of the Meeting. Dr. Low was in the habit of making the final summaries and interpretations after all examples had been presented at the panel meetings. He reserved the right to modify or to correct any statement he considered to be inappropriate. At present, there is no qualified professional who fulfills this function. The group may misinterpret the method or may provide inappropriate advice in areas where lay persons are not competent. It is equally possible, under improper leadership, for discussion at meetings to range beyond the limits of the Recovery method. Surely all of these potential difficulties are possible, and others as well, but the method is so structured as to tend to minimize these dangers. All discussion at the meetings must be presented within the framework of the Recovery concepts and must deal only with trivial examples. The member can also always disregard inappropriate advice.

Relation to the Network of Traditional Aftercare Services. Recovery has no formal connection with any facilities, agencies, or professionals in the mental health field. Because of its relative isolation from other potential sources of help, Recovery is in the position of providing a limited range of services to its members. It may not be able to refer a member to other sources of help which may be necessary. A potential consequence of such isolation may be the development of anti-professional attitudes, and reluctance on the part of the members to obtain professional help when it is necessary. Anti-professionalism need not always be a characteristic of a lay-run self-help organization. Alcoholics Anonymous, which is completely lay run, appears to have good relations with professionals and in many instances has cooperated with professionals in order to provide maximum help for the alcoholic.

Control of Deviancy. An important problem arising from the utilization of lay-run groups for emotionally disturbed individuals involves the possibility of their becoming channels for deviant behavior. Groups like Recovery, because of their unique composition, may foster bizarre and maladaptive behavior on the part of the members. Such groups may be tolerant of behavior which elsewhere would be considered deviant, and may produce deviant group norms. In this sense, such groups may become "fringe" or "crackpot" types of organizations.

The possibility of this kind of development, however, appears to be minimal. The survey of membership has strongly suggested that the organization is not composed of marginal individuals, but rather is made up of persons of solid middle-class status. Observation of group meetings has not uncovered unusually predominant manifestations of abnormal or unacceptable behavior. The philosophy of Recovery, rather than being deviant, resembles in certain respects the general ethos of middle-class American society. The value placed on salvation through work and effort is strongly reminiscent of the Protestant Ethic. The focusing of the Recovery method on concrete symptoms can be compared to current pragmatic and behavioristic ideologies. Finally, the inspirational nature of Recovery is in line with the current fashionableness of "positive thinking." If Recovery is a deviant organization, it is not deviant because of its philosophy or because of the type of members that it attracts; it may be deviant, however, in the sense that it stands outside of the network of traditional rehabilitation and aftercare services.

PROBLEMS RELATED TO THE RECOVERY METHOD

The Rigidity of the Recovery Method. The Recovery method is to be literally applied to all examples presented at the panel meetings. The method is viewed as a perfected, finished system of self-help and aftercare. No provision is made for any changes in the

Recovery concepts and techniques, nor is such change viewed as desirable. Questioning of the basic assumptions of the method is not permitted.

The great concern displayed by Recovery leaders and members over the faithful application of the method prevents individualized consideration of each member's problems. The tendency is to change each panel example so that it fits the method, rather than to modify the method so that it applies to the example. As a consequence, appropriate consideration of an individual's problems may have to be rejected in order to maintain the Recovery method intact.

The Recovery outlook contrasts sharply with the position of Alcoholics Anonymous. Although A.A. has a basic set of "Traditions" and "Steps" which in certain respects are similar to the Recovery method, they are not so literally and rigidly employed in all instances as is the Recovery method. A.A.'s position, briefly stated, is as follows. "Nobody invented Alcoholics Anonymous. It grew. Trial and error has produced a rich experience. Little by little we have been adopting the lessons of that experience, first as policy and then as tradition. That process still goes on and we hope it never stops. Should we ever harden too much, the letter might crush the spirit. We could victimize ourselves by petty rules and prohibitions; we could imagine that we had said the last word. We might even be asking alcoholics to accept our rigid ideas or stay away. May we never stifle progress like that!" (1).

Of course, the rigid application of the Recovery method may also have certain advantages. The schedule of the meeting may prevent discussion from extending into areas in which the members may not be qualified. The method prevents the giving of advice to members outside of the context of Recovery terminology, and serves to control the content of discussion. In addition, the feeling that the method is perfect and can help all members is in line with the inspirational aspects of the organization.

The Stress Upon Control. Recovery emphasis upon control may provide members with defenses against anxiety, and may help them to cope with their symptoms. However, the basic concern over emotional control may serve to neglect the provision of adequate mechanisms for the release of affect.

Some release of emotion may be a by-product of the catharsis ensuing from the public presentation of a behavioral example, but this kind of release is not a major concern of Recovery. Recovery appears to stress a denial of affect, rather than a release aimed at the establishment of new insights. For the individual whose basic problem is the expression of feeling rather than its control, such a method may be unsuitable. Individuals with over-rigid systems of defenses against anxiety may be harmed by increments arising from the Recovery method. Despite the problems which may arise from the lack of inclusion of a "release" mechanism in the Recovery method, the omission may also serve as a potential safeguard. If emotional content was released at the meetings, it is doubtful whether lay persons would have sufficient skill to cope with such material.

The Superficiality of the Method. The Recovery method does not attempt to probe for the etiology of symptoms. The major concern is the treatment of an individual's problems as they exist at the present. Problems are viewed in the form of symptoms, usually presented in a highly concrete, somaticized form. Dynamic interpretations are not permitted, as they are outside the realm of the method. The total effect may be the temporary suppression of the symptom rather than recognition and management of underlying cause. This suggests that any help that the Recovery method provides for a person may be temporary. Symptoms which are suppressed in one form may reappear in altered context. Observation of panel meetings has indicated that although members tend to report successful coping

with symptoms, such symptoms persist from meeting to meeting, changing only slightly in form.

The Regressive-Infantilizing Aspects of the Method. Although the Recovery method places much emphasis on self-help and individual initiative, it nevertheless encourages the member to submit to a higher form of authority. The member must unquestioningly accept the Recovery method in its entirety, with the image of Dr. Low as the supreme authority. The method leads the individual to reduce complex psychological problems to concretized somatic symptoms. The participant is given certain basic tools of a highly ritualized nature, which are to be used in warding off anxiety-producing situations. The new Recovery language which is supplied to the individual creates the appearance of verbal labels which are to be manipulated. For certain people, the employment of these aspects of the Recovery method may tend to force adjustment at low levels of psychological maturity. The individual is placed in the situation of a child who must obey a father figure and use certain semi-magical rituals. He is to gain salvation through complete obedience. Individuals capable of deeper insights into the meaning of their problems may be forced to regress to obtain psychic equilibrium.

Dealing Only with Symptomatology. Recovery provides help for an individual only in reference to his symptomatology. It does not deal with such areas as his potential for growth and development. Its focus is limited to maladaption in effect to the "unhealthy" facets of the participant. There is no clear conceptualization in the Recovery method of what the healthy person is like. All members must constantly present examples of their problems and difficulties. The leaders, who serve as role models for the newer members, present these types of examples most frequently. The majority of Recovery group meetings are concerned with the various symptoms individuals in the group may experience. As a consequence, the group appears to be at all times concerned with illness. For the individual with a potential for growth beyond his immediate symptoms, the great concern in Recovery over symptomatology and illness may well be over-restrictive. As a consequence, for some persons psychological growth may be impeded.

There are certain safeguards within the Recovery method which to some extent serve to counteract this preoccupation. All examples and problems must be discussed within Recovery terminology. A time limit is placed on all discussion, and descriptions must be of an objective, concrete nature. These features of the method may prevent the degeneration of the panel examples into "gripe sessions." However, they may not eliminate completely the basic preoccupation with illness which is shared by the members.

Emphasis on Inspiration. The focus upon inspirational aspects in Recovery may prevent individuals from obtaining a realistic appraisal of the severity of their illness. Certain members may be given a false sense of complacency as to the actual nature of their problems. Because of Recovery's emphasis on inspiration and the belief that the problems of all members can be successfully coped with through this simple method, persons on the verge of acute episodes may be prevented from obtaining necessary professional help.

Cost of the Nervous Patient Role. An earlier section of this report has discussed the type of nervous patient role which membership in Recovery may imply. This role may lead to certain basic problems. It may stigmatize the member by formally defining him as different from other persons who are not emotionally disturbed. It may force him to view all of his behavior from within the cognitive framework provided by the role of a patient. As a result, he may have difficulty in perceiving himself in any other way. This may tend to reinforce his feelings about his illness. The role may be a permanent one: there are no mechanisms for a formal termination of

it. The individual's integration into community life may be significantly impeded. If maintenance of the role permits the individual to remain outside of the hospital, and to be reasonably productive, it may serve a positive function despite its limitations and relative permanence. And the group to which he is attached by the role of patient may provide him with a certain amount of support that could not be found elsewhere.

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CONSIDERATIONS ON RELIGION IN RELATION TO PSYCHOANALYSIS AND PSYCHOTHERAPY[1]

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Some ten years ago I first attempted to present my views relevant to the question of the interrelationship of psychiatry and religion. That paper (5) had to do with the general question of the utilization of social institutions by patients as an integral part of the defensive pattern in emotional disorders. A religious institution was chosen for purposes of illustration since it is exceptionally well structured and since its broad public acceptability makes for especial therapeutic problems insofar as it may be used for neurotic purposes. In those circumstances the social institution itself may become a means of warding off anxiety, but it may have certain potentially destructive aspects unless attitudes are modified during the course of treatment. The purpose of this paper is to elaborate on the more specific considerations having to do with the religious experience itself both in the emotional disorders and in the state of emotional health.

The deleterious impact of the emotional disorders upon the communication of feelings and ideas is well known. In such disorders the tendency is towards isolation, non-communication and interference, accordingly, with relationships with other persons and institutions. They therefore interfere with relationships to formalized social groups as well. Meaningful comparisons may thus be drawn between the social institution, with its tendency to enhance communication and to make for individual interactions within the group, and the non-neurotic individual who also tends towards interaction with others and away from isolation. This has been elsewhere documented by presentation of appropriate case material.

All religion must deal in one fashion or another with the obsessional neurotic's tendency to overdo and to thus make a mockery of the dicta which are a necessary part of any institution. Some fraction of these people can perhaps be coerced away from their over-rigidity but, for the most part, the more they are coerced the more over-conscientious and self-righteous they become. They are exceptionally difficult to deal with since they are superficially most cooperative and obedient. Where such problems are best dealt with through the tenets of religion, and where they are best dealt with by the psychiatrist, is sometimes a fine question.

The interest of the psychiatrist necessarily centers upon emotional disorders and the means of therapeutically modifying them. In association with this, those modes by which man lives out his existence are matters of concern. These must include the totality of his experience both as it may arise from inner causes and from the interpersonal and social structure surrounding him and interacting with him. In this context the religious life of man becomes a matter of considerable interest to the psychiatrist. By and large, the psychiatrist can make no claim to special knowledge in the field of religion as such, nor can he claim authority in the field of the comparative study of psychiatry and religion simply on the basis of his expertness in psychiatry. As a psychiatrist, however, those aspects of man's existence which are influenced by and in turn influence the structure of religion are matters of necessary interest. Some implications may, however, be drawn from the psychiatrist's in-

[1] This article is based on the 1959 Virginia Beyer Memorial Lecture presented at the Springfield State Hospital, Sykesville, Maryland.

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sights which may be applicable to the religious way of life.

It has become a custom in recent years to point out the similarities and common goals shared by psychiatry and religion. In the current pressure to emphasize similarities in this direction, it is easy to overlook their essential points of difference, to the injustice of both. The old conflict between science and religion need hardly affect us, since, to emphasize the special character of science and religion need not be prejudicial to either. To draw one-to-one correlations between them is, however, to compare apples to oranges. True, they are both fruit and true, both religion and psychiatry have to do with human beings, but the intrinsic character and aim of each would seem to be substantially different.

Psychiatry is first and foremost the medical specialty that deals with mental disorders of various degree. Religions of all kinds constitute systems of beliefs in some supreme being or beings through which the ethical and moral nature of man and hence his well being as an individual and a social being may be secured. That these two functional spheres will have areas of common interest is as evident as the fact that their central core is of a decidedly different character.

It is not of the nature of psychiatry to dictate the terms in which man may be at peace with himself and others. It is fundamental to modern psychiatry, however, that adequate interpersonal relationships are the bedrock of mental stability. While this was implied in the entire frame of reference of modern dynamic psychiatry, it was left to Sullivan to bring this into full focus. Psychoanalysis had already heavily documented the role of experiences with others as essential components in character development but the emphasis upon interpersonal factors sharpened up the thesis that human behavior is positively directed towards the goals of collaboration and of mutual satisfaction with other persons, unless it is interfered with by a disordered state. It thus iterated in clearer terms a point that psychoanalysis and at least the more advanced forms of religion have always shared. That is, that mature love is a compelling force in life and that only through a full expression of it can man hope to find fulfillment in his existence.

It is always a question in therapy with regard to religious matters as to where one has to do with questions of psychopathology, the legitimate realm of the psychiatrist, and where one has to do with questions of man's relations to himself and others which are normal in nature and insofar as they have to do with formalized religion are better dealt with by an appropriate religious person. This because they are in a realm where the psychiatrist can claim no especial expertness. Humility and a proper appraisal of himself in relation to his skills is no less appropriate in the psychiatrist than in other people.

In any kind of psychotherapy it would seem that, in addition to the search for etiological factors in the disorder and the search for and attempts to modify meaningful patterns of reaction which mediate against emotional disorder, it is necessary to preserve as fully as one can the spheres of character development which are relatively intact. From these, given sufficient freedom from his illness, the patient may go about establishing (or re-establishing as the case may be) a more stable and satisfactory overall characterological existence. In appraising spheres of stable development it would be quite as wrong to assume that anything that presents itself in the guise of religion is stable, as to assume that the reverse is true. The psychiatrist is an expert in psychopathology and it is part of his function to identify and separate out the the psychopathological from the healthy and to do so without reference to personal taste or prejudice. Insofar as this has to do with religion, whatever his private religious views may be, he must be able to approach the problem in quite the same fashion as he

approaches other significant areas in the patient's life. It is never the function of the psychiatrist to impose his private system of morals upon the patient. To suggest the practice of Catholicism, Protestantism, Judaism, or Atheism on the patient's part is a perversion of the therapist's role. He represents an ethical force in the patient's life only within the broadest meaning of that term.

Since religious institutions are administered by mortals it follows that they are subject to the same errors and the same distortions of intrinsic intent as is true in other human institutions, including psychiatry. An unerring path through the wilderness is left, even in religious circles, to the lot of the Deity alone. Man must struggle on as best he can, hopefully more in the path of love and mercy than otherwise, but never with unfailing guideposts. This being so, it is incumbent on man to engage in the religion of his choosing with an appropriate sense of humility and thus of his own self-limitations and accordingly of the misuse he may make of the teachings of his religion. This is not to say that he must deny himself or the institution appropriate self-respect since this is not incompatible with humility, although this is often falsely felt to be the case.

Nowhere can the distortions of religious teachings by individuals be observed in purer culture than in the emotional disorders. If we are prepared to assume that emotional disorders differ in degree rather than in kind from the normal human, they offer some valuable insights on the potential direction of distortions of religious teachings. I have elsewhere elaborated on the misuse of a religious institution in the service of an emotional illness (5). It is, however, a theme of sufficient importance as to warrant some further development, especially since, from the psychiatrist's viewpoint, it may represent an issue in therapy and may require special techniques in that context.

In appraising the role of religion in psychiatric disorders, it must be viewed as not only a social and idealistic institution but also as the content of defensive maneuvers. In this context, as has been developed by others, the paranoid religious delusion may be a restitutive as well as a destructive maneuver. In order to fully appreciate the significance of and to be most helpful with such patients, it is necessary to have some sense of the meaning of ideation of this kind. When the paranoid schizophrenic proclaims that he is Christ, this may be a valiant attempt on his part to establish a measure of oneness with a savior when he is himself faced with the feeling of utter devastation and destruction. It may thus in fact be a turning to God, in a way which is surely distorted by his illness, but which is not without some measure of resemblance to the most profound piety. It certainly differs from this latter in that it is socially isolating and tends to make for a disruptive pattern of living, but perhaps the need expressed in it might be treated with a greater measure of respect if its desperate reparative nature is more fully appreciated. Even within this context, however, the religious delusion itself serves as a means, however tenuous, of re-establishing relatedness to others. As is often evident, there is a pressure within the patient to verbalize and to so act out his delusion as to communicate it to others and to thus hopefully share it and validate it (2).

The opposite picture, that of a destructive delusion, sometimes to be observed in the very same patients on other occasions, is the vast sense of isolation and of inner emptiness they experience when they feel a sense of separateness from their mystical union and oneness with God. This is often manifested by fantasies of the "end of the world" and by states of depersonalization.

The affective state of guilt is a dynamism of exceptional importance in relation to the present topic, and the experience of guilt has numerous relevant implications. In the psychoanalytic frame of reference, guilt is the ego response to the attitudes of the

superego. The terms ego and superego have special implications which the concepts of self and conscience do not embrace. These latter have to do with processes, of great importance certainly, but limited to the scope of awareness or consciousness. The conflict between ego and superego may be largely unconscious; the resultant guilt may be present as a feeling, or may be manifest only by self-destructive behavior from which we may imply some inner unconscious guilt experience. One can illustrate such behavior by an example I have discussed in another place (4). A child brings a slip of paper to an examination, containing answers to anticipated questions. On completing the examination he takes his paper to the teacher and, at that instant, drops the slip of paper at the teacher's feet. While one cannot utterly rule out the element of coincidence, the evidence seems strong that this mishap is a product of a conflictual situation going on outside of consciousness. Without awareness the child brings down punishment on himself to absolve his guilt.

As may be surmised, the conflict between the ego and the superego may be a result of a malfunctioning ego with the superego being a relatively normal organization, or it may be a result of superego distortions with a resultant destructive impact upon ego function. The former situation is more apt to be found in the normal character and is of a kind which lends itself to possible solution from religious sources and, indeed, the suggestion has been made by some that psychotherapy may be conducted by bringing the ego into line with the superego and thus avoiding conflict. In this situation, stress is placed upon the conscience and upon the need for heeding its dictates, certainly a familiar theme. Modern psychiatry, however, has largely operated upon the premise that the largest proportion of the treatable emotional disorders, at least, are a resultant of the impact of a cruel, distorted superego upon a relatively intact ego. Therapeutic efforts are thus centered upon attempts at alteration of the superego.

As with the conscience, so is the superego envisioned as a punishing or rewarding internal authority. This role may have to do with past events, in which remorse may be prominent, or with future events as a type of guidepost and director of behavior. There is a strong tendency to project this authoritative role upon some person in the environment who is either in the immediate proximity or only fantasied. This has rather evident implications both for the therapeutic situation and for various theories which have been propounded in connection with religion.

The capacity to project upon external authority the ability to punish or love seems to have a broad economic function. Rather than having to deal with the special stresses of a painful inner conflict, one of the conflictual forces is put outside in some relatively more tangible form. In the therapeutic situation this is evidenced as one aspect of the phenomenon of transference, where the therapist is envisioned as this authoritative figure. Deriving as it does from earlier parental relationships, later experiences in religious life may bear many resemblances to an equivalent external authoritative figure. Although by its nature heavy stress is placed in psychiatry upon the misuse of authoritative systems, the advantages of an adequately functioning, socially oriented external authority system, whether viewed as a projection or as a thing in itself, are considerable. If that system is of a reasonably ethical and moral nature, the result will be a betterment of the interpersonal experiences of the individual.

With this as a background, we may examine a few of its implications. In normal man as in psychopathologic states, life is by no means devoid of insecurity and of stress. The authority, whether it be envisioned as internal to oneself or in some projected form, offers some measure of security but at the

price of the experience of guilt. The experience of guilt is an immensely powerful signal that the authority is present and that security and love are available if it is only heeded. It is through this that the thesis has been developed in many circles, including psychiatric circles, that guilt is the natural state of man. The theme of having committed the unpardonable sin, so familiar in the emotional disorders in one or another form, is the extravagant, exaggerated form of a theme which all men share to some measure and is a familiar one in theology as well.

There is one particular issue which bears some mention in the present context. There are some individuals who are obsessively preoccupied with certain thoughts which they feel would be considered sinful by the religious group of which they are members. These individuals sometimes state that they have been instructed to put such thoughts out of their mind by their religious counsellors. While, in the healthy personality, such techniques of suppression and repression may be practiced to good purpose, in psychopathologic states the very mode of therapeutic approach is based upon bringing into awareness just those disturbing preoccupations and fantasies—in order that the conflictual situation may be examined to its fullest so that it may be therapeutically modified. This constitutes a not inconsiderable problem in therapy in that the patient's guilt may be intensified by the very act of the therapeutic approach.

The operation of repression for such persons may have a harmful effect upon their personal as well as their religious life since, by repressing the given theme and thus banning it from consciousness they may avoid the experience of guilt but may engage in behavioral patterns which are substantially destructive to themselves and others. While in the normal personality the forced withdrawal from potentially harmful fantasies may reduce the possibilities of carrying them out, in the very widespread emotional disorders the reduction of such fantasies may have just the opposite effect insofar as they have constituted a necessary escape valve for suppressed emotion.

Another issue bearing upon the theme of guilt which may occur in the therapeutic situation has to do with those patients who envision the very experience of pleasure itself as bad or sinful. This may be the pleasure that comes with work which is to the common good, nor does it have by any means to do with immoral or sinful acts particularly. Now in some such instances it is seen that the source of the pleasure, while apparently praiseworthy in itself, is reminiscent to the patient of some forbidden pleasure. In other instances, the stamp of disapproval seems to stem from parental, social or religious sources which have implanted within the superego the thesis that pleasure is in itself evil and sinful. Insofar as psychotherapy is concerned, the issue is often a most serious one in assisting such an individual in obtaining the legitimate fruits of his productive labors. In this context certain attitudes may be obtained from parental or social (including religious) sources that sexuality is intrinsically sinful under any and all circumstances and that man is born in sin. This seems to be a thesis which in the healthy personality may not interfere with a normal sexual existence. If, however, there are the seeds of emotional disorder, such a thesis may have a profoundly disruptive influence and may be a necessary sphere for therapeutic intervention.

A logical extension of the phenomenon of guilt has to do with certain aspects of problems arising from the dependency on authority, insofar as they have special relevancy to the interrelationship of psychiatry and religion. The human begins his existence with a long period of helplessness and dependency on others. Psychiatry has emphasized the degree to which the state of helplessness of the infant functions as a means of dominating and controlling his environ-

ment. Of course in the process of psychiatric treatment the patient employs equivalent techniques in his regressive attempts to secure a mystical kind of security from the analyst who is envisioned as the parent or all-powerful protector.

In the psychiatric situation one can observe certain attitudes towards religion and prayer which would suggest that there are those who make infantile, regressive demands upon their deity which are of a kind with the demands made by some patients in therapy; while there are other patients whose dependency relationship and hence their religious life bears the stamp of a more mature interpersonal relationship. While the term dependency has acquired something of the aura of an epithet, no man can live in a state of utter isolation, and a healthy degree of interdependency surely is a condition for a constructive existence. This would apply not only to the relationship of man to man but of man to his authorities, be it in the form of a deity or otherwise. This has evident implications for man's attitude toward God and toward prayer; that is, the terms in which he proposes to communicate and to deal with his deity. The implications from the theory of interpersonal relationships at a more or less mature level are broadly applicable to the attitudes that man takes in his religious life, and there are the same opportunities for a more or less mature relationship.

In order for one to engage in any healthy interpersonal activity, and I am hard put to find any other sort of healthy human activity be it in fact or in fancy, man must have some measure of faith and trust in others. In each and every instance he cannot explore fully in advance, and engage in relationships only on the basis of established fact. For example, Freud suggested that in approaching the analyst the analysand do so with an attitude of "benevolent skepticism." This does not imply a fully developed trusting relationship, but suggests a readiness to engage in such a relationship. Within the psychiatric context at least, such a capacity to engage in relatedness implies that some prior experience or experiences had been engaged in with a measure of satisfaction. Clinical experience further suggests that such satisfactory experience usually occurs very early in life, usually with the mother or mothering person.

Modern dynamic psychiatry has laid a necessary emphasis upon the genetic factors out of which emotional disorders may arise. In the process, there has been a relative neglect of the present moment of living, and, even more so, man's envisionment of his prospective existence. Man's present mode of existence is dependent on his prior experiences in living and his prospective view is as well influenced by prior experience. It does not follow, however, that his prospective view of his existence is utterly a product of prior experience. This prospective view of his existence mutually influences his present mode of existence and is influenced by it in turn. As may be seen, the present moment of existence is a unique experience, never to be repeated in its totality at any other point in existence, and influenced by prospective anticipations and retrospective memories (3).

In this context, far greater emphasis must be given to man's anticipations for his future existence as a dynamic factor of major importance in moulding his life. The implications of this in terms of his goals and ideals are not inconsiderable and have been inadequately emphasized in psychiatry. As may be seen, religion is one potential source among others of such ideals, and the exploration of the sources and dynamic impact of these ideals is a point of near-convergence between psychiatric and religious thought.

The thesis of man's goals and ideals are intimately bound up with the psychologic concept of the ego ideal. One must distinguish the ideal figures with which man chooses to identify himself from the superego as discussed earlier. Such ideal figures

probably originate in very early attitudes toward parents and is later continued in terms of teachers, religious figures, and so on. Psychoanalysis has tended to place justifiable stress upon the earlier phases of this process and has emphasized the importance of having adequate figures with whom to identify and to strive to emulate, at an early period in life, that is before the age of six. Yet psychoanalysis has not until recently come to appreciate fully the formative impact of the teacher, the minister and other significant persons during the course of maturing. Needless to say, the Deity as envisioned in one or another religion may serve as just such an ideal figure, with the further advantage, to some, of having a sustaining quality which the human who is idealized cannot have upon any permanent basis. With these latter, the ideal carries the seeds of disappointment in his very humanness, with its inevitable limitations. The ego ideal is not something that man can ever fully be, but in the process of striving towards it he may enrich his existence. Insofar as he may from time to time approximate his ideal, he experiences a brief sense of the full richness of life.

The adult personality is based in infantile attitudes, but consists of additions and changes in its infantile counterpart as well. Therefore its means of relatedness to others is radically different in character. Thus, remaining strictly within the psychiatric frame of reference, man's object relationships, be they to other men or to his conceptualization of God, cannot be defined simply in terms of infantile attitudes towards parental figures. While they undoubtedly relate to such attitudes, to define them simply in such terms is just not enough. However useful the emphasis upon such primitive attitudes may be in the process of therapy, the aim in that context is the specific one of overcoming disordered function, and its prime concern is not the theory of personality.

One must not underevaluate the impact of the biologically based drives and of the infantile attitudes on later character development and especially so as it bears upon the process of psychoanalysis and psychotherapy. From infancy there are certain biological needs, for food, warmth, etc; which become intimately bound up with, and merge over into certain mental and feeling attitudes towards the supplier of these things, usually the mother. It seems likely that such earlier relationships would have a profound impact on the developing character either in a constructive or destructive direction. With increasing maturity, however, the character structure or ego becomes increasingly autonomous and thus less closely bound to the drives, although always bearing a considerable relationship to them. As a result of certain therapeutic considerations in the emotional disorders, some measure of confusion exists as to the mode of operation of the normal character. In the therapeutic frame of reference it is important to explore such genetic background with the patient, with the intent of understanding the meaning of certain modes of disordered function which constitute the emotional disorder. Hence therapy places a heavy emphasis upon such genetic considerations and upon the sources of such disordered adult attitudes.

If, however, the same problem is approached from another point of view the outlook is quite different. The complex attitudes of the normal adult character are a product of the drives as well as of heavy contributions from the ego itself and from the social environment, by means of contact with significant persons. If one considers this complex series of attitudes—affectional as well as ideational and behavioral—only from the standpoint of the drives, much of the adult character is ignored. Such a constricted view occasionally yields up a fantastic observation, *e.g.*, that a fine oil painting is nothing more than a sublimated version of the drive part-impulse towards smearing feces. Agreed that the urge towards smearing finds expression in the work of art, it is

far more than a simple expression of this impulse. It is a complex ego operation involving subtle technical skills and most complex emotional attitudes deriving, not only from the drives *per se*, but from experiences in living as well. Curiously enough, more recently, with the fuller recognition in psychoanalysis of the nature of these complex ego attitudes, there has been the tendency in some quarters to give too little rather than too much cognizance to the genetic components of adult behavior.

The fact is that the capacity of man to undergo constructive changes is rooted not only in the therapeutic reconsideration of early life experience, although this has been one very fruitful channel, but also in an ever continuing series of more or less significant current experiences with others. It is true that prior experiences may have been such as to exclude the capacity for present experiences with others for some persons, but this is by no means always the case. As might be expected, this variability has made for a broad range of therapeutic approaches, each of which claims therapeutic successes, and has made for a number of situations where engaging in religious or other pursuits has been of great value in modifying character structure in a constructive way. This may have some relevance to the constructive aspects of differing religious beliefs as well.

The question comes up periodically as to the terms in which one might describe, psychologically, the fusions of the structural units of personality under consideration here, as exemplified in the so-called "oceanic feelings," for instance. It is within this variety of experience that one would place man's sense of ultimate oneness with his deity. Some few claim to have had this experience in the absolute sense, and many have experienced it in some degree or another. In psychiatry, it is fitting that the descriptive framework be a psychological one and nowhere does it become more clear that this mode of approach to the study of man, like all other approaches, has stern limitations. The closest one can come to describing such states in psychological terms is one of fusion and unity between id, ego and superego. That is, the unity of that which is a product of his animal heritage, that which constitutes his own personality in the narrower sense and that which he acquires from other persons. That such unity should be rarely if ever achieved in life is only to be anticipated in view of the potentially conflictual nature of its ingredients.

So far, this does not fully account, even in a psychological sense, for the feeling of unity with another, be he man or the Deity. To continue within the psychological framework, man is aware of the world about him through his senses and through the memories of prior sense experience. The experience of total unity with another, as an experience, must be internal to the self. However much such an experience may be perceptually displaced to the outside, man is dependent on his senses and his inner interpretation of them for his knowledge of and feelings toward others. This would by no means deny or affirm the existence of other persons or of the Deity in itself—psychologically such experiences are inner experiences, whatever else they may be said to be.

Any examination of the human personality, whether in terms of psychological drives, of id, ego and superego, in terms of the theory of perception, or in terms of genetic versus present experiences, surely leaves something to be desired. Within these contexts, the living functioning human animal is too much of a series of dynamisms and mechanisms, and lacks something of the quality which we see in others about us or in ourselves in the present moment of being. Whether this is an inevitable deficit of any approach to the functioning of and to the problem of the nature of man, I do not know.

I have not chosen to take a position which either lauds the virtues of religion or decries it. Like other means by and through which man may choose to live, religion may be a constructive or destructive experience and, in fact, the institution itself, administered as it is by mortals, may take on a constructive or destructive coloration. Man reaches out for some measure of stability and security in the unsettled world of today and, for some, religious practice constitutes an immense source of it.

Psychologically, many factors enter into the religious experience, some few of which have been considered. The engaging with others in a highly ritualized, relatively fixed experience, as represented by the religious service itself, is a source of security and satisfaction for some persons. This is especially meaningful at the present time and may account, to a degree, for the current recrudescence of interest in religion. In modern times our sense of geographical stability and, with it, our sense of tradition and of family ties, is in the process of a violent revolution. Our culture is experiencing the impact of change in many connections. A dramatic example in psychiatry is increasing the problem of care of the aged. In part this problem is associated with the development of the antibiotic drugs, with resultant longevity, but it is also the product of modern modes of living, where family structure leaves little room, even in a physical sense, for the aged in the home.

While modern life offers many thrilling and exciting sources of stimulation, it fails us in that there is a deficit in the degree of structuring and of traditional, stabilizing activities which are available to us. For the most part we are apt to look upon the changing and the exciting as the desirable, and to place too little emphasis upon the regularly repeated activities, duties and responsibilities as a critical source of security and of fullness of existence. Such regularity in existence is a necessary condition for an inner sense of stability and of a sense of inner worth, at least in our social conditions. In this context, religious practice must certainly represent a potential source of such security for many persons.

In conclusion, it seems appropriate to say something about the mutual respect of man for man, and of institution for institution. The psychology herein described is a psychology of conflict, and the very subject matter of psychiatry and religion has been the source of much bitter feeling. In psychiatry as in religion one often observes the search for the ideal type, be it in terms of the fully analyzed person, the saint or the devout of a particular sect. Respect for individual difference is hard to come by in any circumstance. William James (1) stated this matter in a particularly poignant way. He wrote, "It has often been supposed, and even now, I think, it is supposed by most persons, that there can be one intrinsically ideal type of human character. A certain kind of man, it is imagined, must be the best man absolutely and apart from the utility of his function, apart from economical considerations. The saints type, and the knights' or gentlemans' type, have always been rival claimants of this absolute ideality: and in the ideal of religious orders both types were in a manner blended. According to the empirical philosophy, however, all ideals are matters of relation. It would be absurd, for example, to ask for a definition of 'the ideal horse,' so long as dragging drays and running races, bearing children, and jogging about with trademen's packages all remain as indispensable differentiations of equine function. You may take what you call a general all-round animal as a compromise, but he will be inferior to any horse of a more specialized type, in some particular direction." In our appraisals of human character, therefore, we may find room to respect and to value many variants which if measured by the standards of compliance to a given type would be sadly deficient.

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ACQUIRED SPASMODIC TORTICOLLIS IN A MALE HOMOSEXUAL

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Spasmodic torticollis is usually defined as a condition arising principally in adults in which the muscles of one or both sides of the neck are affected by recurrent clonic or tonic spasms which force the head backwards or rotate it sideways into unnatural postures. The recurrent spasms cause considerable aching and usually disappear during sleep. We have evolved a definition that psychodynamically would include any spastic movement of the head or neck that recapitulates an earlier passive experience, returning from repression under the stimulus of a later situation.

Etiology: Considerable divergence of opinion continues to exist. Functional explanations suggest that the disease is the result of unconscious emotional conflict. Organic explanations focus on a central nervous system lesion, possibly in the corpus striatum, subthalamic nucleus, corpus pallidum or related structures.

History: Wepfer (4) described the occurrence of involuntary motor activity of muscles of the neck in 1727, but did not attempt to differentiate them clinically. In 1870, Cruchet and Brissaud (1) described a "mental torticollis" and felt most cases came under this broad category closely related to "tics" or habit spasms. Wilson (11), in 1900, classed it under the heading of "neurosis." Later, however, general lack of success with psychotherapy led observers to believe an organic lesion might be the cause. Foerster (2), in 1929, said the psychogenic origin theories were exaggerated and described cases starting out as torticollis and going on to widespread dystonia, athetosis, etc. He also reviewed autopsy material showing lesions in corpus striatum and vestibular nuclei. Herz and Glaser (5, 6, 9), reviewing 75 cases they had studied over some years at the Neurological Institute, Presbyterian Medical Center, New York, in 1949, stated, "we feel that in all cases an organic disorder of the brain structure is responsible for the production of the typical involuntary movements. The clinical picture, however, may or may not be the resultant of additional conditioning by psychogenic factors of a variable degree." It has been remarked by Garnett (3) that "in all of our cases the symptom of torticollis was an eloquent expression of the patients' conflict or dilemma."

Diagnosis: The literature also reflects some difficulty in differentiation. There is a problem of discriminating between cases of spasmodic torticollis and those of dystonia musculorum deformans. Torticollis may be a fragment of dystonia musculorum. It has been thought of as a local dystonia whereas dystonia musculorum deformans is a more generalized disease. It is interesting to note that in Wechsler's *Textbook of Neurology* (10), dystonia musculorum deformans is classed under "disorders of motility and diseases of the basal ganglia" which also include Wilson's disease, paralysis agitans, Huntington's chorea, etc., whereas spasmodic torticollis is classed under the chapter entitled, "Tics, Spasms and Myoclonias."

Prognosis: As the disease continues various prognoses are possible. A few cases can go on to spontaneous remissions, temporary or permanent. Others continue at a fixed level for many years and the individual may die of completely unrelated disorders. There seems a point, however, in many of the reported cases, beyond which the likeli-

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hood of any real improvement is remote. It is entirely possible that in these cases irreversible organic "degeneration" has occurred in the areas mentioned. One can speculate as to the anatomical, biochemical, nutritional, enzymatic or other changes that have occurred.

Treatment: We believe that unless proved otherwise any repetitive involuntary movements of the head or neck should be intensively and vigorously explored through a psychodynamic interviewing technique as early as possible before secondary organic changes—if they are going to occur—have time to distort the clinical picture and to distract the clinician from the emotional forces which are responsible. A variety of surgical measures have been used, including section of the spinal accessory nerves and of the upper cervical nerve roots, together with extensive myotomy of the neck muscles, even leucotomy, but the results are poor. Poppen and Martinez-Niochet (8) performed extensive and often mutilating operations on 36 reported patients, but had to admit failure in nearly half their cases. In the remainder they obtained varying degrees of improvement, at the expense of some disability through weakness, but no cures. Wycis and Moore (12) report on the successful surgical treatment of nine cases but conclude that, "because of the hazards involved and the muscle deficiences it produces, the operation used in these cases is not the answer to the problem, the etiology of which remains obscure."

The following is a case presentation which we feel further demonstrated the "doctor's dilemma" in proper management and lack of understanding of this strange malady.

CASE PRESENTATION

This 37 year old man was a co-owner of a bar located in the financial district of the city. He had been the private patient of one of the writers for four years prior to the onset of the torticollis. His first complaint was "neuritis" of the neck for two weeks. He was treated once, three years previously, by an osteopath for a similar complaint. He described the pain as being located over the back part of the neck with accompanying stiffness which increased as the day progressed. He noted improvment on weekends when he was not working.

Physical examination revealed a healthy looking, lean male of medium stature, whose gait and station were not remarkable. The only positive physical finding was a stiffness of the entire posterior cervical musculature. Cervical x-rays were negative. Despite two weeks of treatment with mephenesin, followed by two months of physical therapy, there was no improvement. Following a psychiatric consultation, hypnotherapy was carried out for two months on a weekly basis. Almost complete disappearance of objective neck symptoms for an hour after the session was reported. After several weeks of this treatment, the patient improved and insisted on discontinuing therapy. Within a short period his symptoms returned. The patient sought other medical opinions, advising us subsequently of his actions. His studies included electroencephalograms, skull x-rays and spinal fluid examination. At this time he still had some control over his neck movements. The administration of chlorpromazine in large doses for over two months was also carried out, again with no apparent improvement.

He was not seen again by us for four months, at which time he sought treatment for an injury in a street fight with a stranger. He had been struck about the head and face; a tooth in the right mandible perforated his face at the base of the lip, and there was considerable hematoma about the right face. It was only after this episode that he lost voluntary control over the now more definable spasms of the neck muscle. At this point the diagnosis was changed from simple torticollis to spasmodic torticollis, which progressed during the next three years. A year later he came under our closer observation with the onset of infec-

tion and pain from three impacted third molars. After dental extraction of these teeth, he developed a draining abscess from the left lower gingival margin and had severe pain and disability, with marked increase in neck spasms. Within two months the dental condition had become an orthopedic one with bone resorption of the mandible, and it became necessary to wire the mandible for six weeks to prevent a pathologic fracture. During this period he accepted intensive psychotherapy.

The next change in his condition was noted a year later after he terminated psychotherapy. In addition to his previous symptoms, isolated muscle jerks of the supporting shoulder musculature bilaterally were noted, as well as spasmodic twitchings of muscle groups in the forearms. As a result he had lost the ability for many fine movements of the hands and his writing was very poor. He returned three months later after having gone to another city for neurosurgery. A cervical laminectomy with clipping of some of the posterior nerve roots had been done. Despite a short-lived improvement postoperatively, his condition worsened. It seemed that not only his head and neck but all the upper extremity musculature was now in tonic spasms. For the first time he had twitching and spasms in the right hand and forearm. Facial contortions were marked. His head no longer turned to the left but had such poor support that his chin nearly rested on his chest. There was some muscular wasting of the right upper arm. His posture was bizarre and unusual with marked deviations of the spine and trunk. He returned to his parents' home and within a year had become a complete invalid.

OBSERVATIONS DURING PSYCHOTHERAPY

This man had been a confirmed and practicing homosexual since his college days. In manner he was unassuming and rarely could he more than glance at the therapist even when the spasms would subside. At the same time he was garrulous, seemingly to avoid the discomfort of a period of silence in interview. His major subjects in college ranged from music to architecture to engineering; however, he was unable to complete requirements for graduation. His disappointment in homosexual affairs, as well as the thought and energy so expended, frustrated many plans as well as any academic goals. He had once carried on a short affair with a woman student but soon turned permanently to men. He managed a short wartime tour of active duty as a naval officer without getting into trouble with authority; however, he had considerable difficulty being assertive and concealing his engrossing desire to be passive. Finally, he met the man who remained his partner for many years, and with whom he established a deeply ambivalent, all-pervading attachment. He complained about maltreatment by his partner, who often ridiculed him publicly, who made the decision for purchasing a bar which the patient was afraid to oppose, and who forced him into other investments that he did not favor. They lived together for a number of years punctuated by terminations caused by the periodic eruptions of the patient's anger when he was intoxicated. Then he would obtain an apartment of his own and pursue his idyllic fantasy of a house in the country. At the outset of psychotherapy he was living in a country tract house to which he invited his partner for week-ends. He often felt victimized and imprisoned by his masculinely handsome sexual partner.

The origin of the torticollis was closely linked in time with a major disappointment at not obtaining a loan to build a house for himself. Although he complained about his muscular pulls and stiffness, he was not as alarmed as when the actual spasms began six months later. This closely followed an incident that he instigated with a stranger whom he insulted, and who then chased him into an alley and battered his head several times against a wall. True spasms then

began and his anxiety intensified. Three months later his partner's mother returned from a European trip and began a heightened renewal of a previously mild competition with the patient for his partner's time and attention. The spasmodic torticollis became even more obvious at this time.

He began psychotherapy with much skepticism, anxiety and shame. There was always the lure of other remedies for his affliction, *viz.*, a swimming pool, neurosurgical procedures, sea travel, etc. As the pathological fracture of his mandible occupied more of his attention and limited his activities, many of the psychotherapeutic sessions were filled with derivatives of this physical difficulty, and blunted the examination of ego activities. However, many dynamic implications did emerge.

The patient's parents were alive and had become less unsympathetic toward him during visits of recent years. Nevertheless, he always felt that his mother charted the family course and that he had wanted to get away from her for a long time. He recalled with discomfort his mother's enema-giving tendencies during his childhood. Whenever a woman became rowdy in his bar, or an older woman entered, he invariably felt tense; at worst would feel like striking or ejecting her. When the actual need to evict obstreperous women from his bar developed, he was frightened. Even more than his father, his mother was pictured as a stringent and restrictive person who prohibited smoking and drinking. In dreams he frequently pictured such scenes as his mother driving a car in which he was a passenger, at other times being an assistant to her in various domestic activities, and once having his temperature taken orally by her.

His father had become a docile old man whom the patient had never been able to admire. An isolated childhood memory of his father slapping his face so hard that his head turned; was a key associative link with the episode of having his head slammed against the alley wall by the man he had recently provoked. A subsequent dream of being pushed to a wall by a "Chinaman" brought these associations together. In recent years his father had developed an arthritis that restricted his head movement.

In his long-standing affiliation with his partner the patient perpetually felt hamstrung and down trodden. During sexual play many aggressive and borderline sadistic practices were indulged. The patient sought active fellatio and also active sodomy; only under pressure would he acquiesce to the corresponding passive positions.

The torticollis handicapped his sexual activity and sapped his energy. He had the recurring thought that his malady was punishment for his feelings of anger and his disobedience to his partner, with some threads leading further back to his own father. He offered as a sarcastic solution the giving up of all assertiveness and contrariness. To be rid of his spasms he even fantasied total passive surrender to his partner. He wondered whether his spasms might cause people to know of his sexual tendencies. As his grimaces and posturings became more exaggerated, his appearance ironically became distinctly more feminine. At no time did he ever reveal any psychotic content. Although he tried to rupture all ties with his partner he was unable to do so.

During psychotherapy he was unable to verbalize any feelings about the therapist. After ten weeks of twice weekly sessions conducted vis-a-vis, the patient was asked to lie on a couch and the frequency of meetings increased to three a week. After three more months, he decided to interrupt the psychotherapy for a vacation after which he did not wish to resume therapy. It is noteworthy that on a number of occasions, he awoke from a dream with marked spasms, as opposed to the usual symptom-free awakening with gradually exacerbating spasms.

In one such dream a Negro man had torticollis and then began to fight for his

rights against all adversaries, finally massaging the patient's body. Fear of retaliation for hostile aggressive impulses was apparent, as well as the conflicted activity-passivity axis.

In another dream the patient was climbing stairs from the "Tenderloin" (Skid Row) district to Nob Hill, where he attempted to seize an unknown man's testes, but then found that the man had vanished and instead that the patient was making highballs. Associations led to fantasies toward some of the successful clientele of his bar, with whom he wished to identify. He was able to sense the hostile conflict with his partner, but could not trace it out either genetically or approach it in the transference to the therapist.

The content of several sessions reflected the other major area of conflict. The patient had always longed for the limelight and yet also for a secluded estate where the world would lionize him. Theatrics and sham were often on his mind. Despite his torticollis he continued to function as a bartender until his spasms and secondary movements significantly reduced his coordination and his strength. Though wishing to avoid the stares of his patrons, he found a measure of satisfaction in the attention that he gathered and especially in the solicitude and infinite suggestions that were so freely offered. A third business partner was found to ease his responsibility as the bar continued to flourish. The wish to be seen as well as the intense curiosity about the lives of other people brought him to the bar despite his infirmities.

DISCUSSION

Acquired torticollis, involving musculature over which there is voluntary control, may be used to represent psychic conflict in symbolic form. However, there remains the possibility that certain cases have a fundamentally neurologic origin upon which emotional conflicts may be superimposed. It would appear that there may exist a continuum from the primary emotional origin to neurologic etiology.

Even in those cases of apparent psychogenic inception, degeneration of neurons within the spinal column as well as in the diencephalon may occur in susceptible individuals through a mechanism that has never been elucidated. Consequently, surgical or postmortem findings of neurologic lesions cannot be used retrospectively to specify etiology.

In the patient here reported there are notably close correlations between certain traumatic external events and the worsening of the disease process. How can such experiences have been translated into peripheral muscle spasms?

Patterson and Little (7) discuss the neuroanatomy of this disease and are convinced that on the basis of their muscle studies of the neck, the spasms represent a synergistic integrated action. They say it is necessary to postulate the operation of a definite central nervous system reflex pathway. They feel that the thalamus is necessary for mediation of some phenomena noted, but there is no clinical evidence to indicate that thalamic lesions *per se* cause conditions like torticollis. From their illustrations of the CNS, it is perfectly possible to add connections from the cortex which would then explain cases on a psychogenic basis.

In the present case the data are sufficient to establish typical conversion conflicts whether or not a neurological substrate was present. The character structure of the patient left much to be desired as to his capacity to participate in analytic psychotherapy. Resistance came from his fear of the passivity which divestment of his thoughts signified, as well as from his fear of punishment and of helplessness. If successful participation could have been obtained, would resolution of the conflicts have terminated the torticollis? The presumptive answer derives from the variations in the degree of spasm as correlated with happenings in the psychotherapy and in the patient's life. Though

hypnosis could do no more than effect remissions of less than an hour, these did reveal the power of the psychic factors. Physiotherapy also frequently improved his condition for short periods. As long as the subject's spasms can be reversed at all through hypnosis or comparable procedures, the patient clearly has not suffered the irreversible organic changes which make his disease permanent.

In this case the homosexual impulses and the torticollis do not appear to be causally related. Both serve some of the same impulses and defenses and also mediate the need for punishment. There does not seem to be anything about the homosexual adjustment or lack of it, as such, which has more than coincidental significance as far as the torticollis is concerned. Many other personality structures and problems could obtain.

Whether a specific case of torticollis is a limited or progressive form of dystonia musculorum deformans—for which no diagnostic test is available in its incipiency—or whether it has no relationship to such a neurologic disorder, it should at first be approached as a conversion symptom and the patient evaluated for the relevant emotional constellations.

SUMMARY

The case history of a 37 year old male homosexual who developed simple torticollis and then spasmodic torticollis is presented. Despite his unsuitability for psychoanalytic therapy, enough was learned to demonstrate that pertinent emotional conflicts seemed to be channelized in his symptoms. A differential diagnosis with dystonia musculorum is presented. When torticollis is the only aspect of dystonia, it cannot be differentiated from psychogenic torticollis. Unless a specific neurological entity can be disclosed, it is probably best to give such cases a therapeutic trial of psychoanalysis. Surgery can probably be avoided in most patients who are suitable for such psychotherapy. Actual experiences involving the neck are likely to be of genetic importance.

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THE GANSER SYNDROME: A REPORT OF THREE CASES

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INTRODUCTION

The Ganser Syndrome, first described in 1898 by Ganser (3) as a "peculiar hysterical twilight state," is seldom recognized and infrequently reported. It is usually associated with a life situation which is limiting or constricting and is consciously or unconsciously perceived as such. Naturally, this is the case when an individual enters a prison, and from this setting emerged the first reports of this syndrome. Wertham (10) wrote in 1947 that "a Ganser reaction occurs almost exclusively in jails and old-fashioned German psychiatric textbooks," yet several publications in the English-speaking literature have recently appeared, concerning the occurrence of this syndrome in non-prisoner patients.

This paper will describe three patients who manifested the Ganser Syndrome, one of whom received intensive psychological testing, which so far has not been reported in the American literature. Perhaps the most striking feature in all three cases is the fact that the syndrome developed as the patient approached the moment of release from a freedom-restricting environment rather than upon his entrance into that environment. It may, therefore, be assumed that remaining in an institution must represent a secondary gain to these particular patients.

CASE REPORTS

CASE #1

The patient, a 25 year old single male Negro, with an unstable family background involving admissions to penal institutions, was admitted 18 days before Christmas, in 1955. After his mother's death and his father's remarriage, the patient had been placed in a children's home, and later in a boys' trade school, there completing nine years of schooling, after which he worked sporadically. During the two years he spent in the Army, he was court-martialed three times and after returning home became involved in the use of heroin. He was also imprisoned on a charge of "theft and larceny." Paroled in September, 1955, he soon returned to jail because of "reckless driving while intoxicated." During this imprisonment, he thought of changing his pattern of life and became somewhat apprehensive as he awaited his release.

His good intentions were discouraged the afternoon of his discharge, when asked by a prospective employer, "Who wants to hire a jailbird?", and his "decent life" became frighteningly unattainable. The same evening he "seemed in a daze," was not able to talk, and exhibited peculiar shaking and jumping. He was seen at the Emergency Room of the University Hospitals by one of the writers. The physical and neurological examinations were unremarkable, with no detectable odor of alcohol. He seemed unaware of what was going on around him, did not know his name, address, or the date. He gave incorrect and irrelevant answers to questions, but it was observed that at times subsequent replies were somewhat relevant to areas that had been previously discussed. An example of "Paralogia" or "Vorbeireden" was his statement that he did not know his age; subsequently, when asked to add six and six he answered "25," which was the correct response to the previous question. By patiently disregarding his behavior, he could be coaxed into giving some

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correct answers to questions which he had formerly answered irrelevantly or only approximately. When confronted with his later successes, however, he denied having been asked that particular question, or he would again become irrelevant, and present a picture of pseudo-dementia. A diagnosis of Ganser's Syndrome was made on the basis of the preceding symptoms. In addition, his behavior included histrionic episodes of posturing as in crucifixion and of typically hysterical convulsions. Motor and verbal activity swung between agitation and a silent pseudo-immobility. His mood was one of puerilistic, whining depression, with expressions of hopelessness. At this time no hallucinations were elicited, although he was unable to make realistic interpretations of his situation.

After sleeping for a few hours he appeared to be hallucinated, imagining a "man upstairs" on the floor above who he said was "God" and a "man downstairs" (hearing this voice from the floor below) who, he said, was his deceased father. The content of his hallucinations emphasized his preoccupation over "doing what was right, not what was wrong." At times, he appeared to be confused, shouting such remarks as, "If I learn how to add and subtract (suggesting that he remembered the arithmetic problems of the initial interview), I will understand Catholics. I use heroin, I have an honorable discharge." Then he continued by reciting several other words related only by the initial letter "H." Incidentally it appeared that his behavior was more inappropriate during the quiet evening hours.

The treatment plan was based on the assumption that a threatening situation had played a role in causing this Ganser reaction. It was postulated that his symptomatology should disappear when the external stress giving rise to this particular reaction was alleviated. Therefore he was treated with kindness and his bizarre symptoms were ignored. However, he was made to feel that with more perseverance on his part he would be able to meet his problems. Some help was promised in obtaining employment, as soon as he felt well. No medication or other treatment was given. Within this therapeutic milieu he improved to the extent that after four days he was in good contact with reality. On the fifth day, the therapist asked most of the questions which had been previously answered irrelevantly or not at all. All of his responses were in accord with his intelligence, and all defects in premorbid memory noted upon admission were absent. There was, however, a definite amnesia for his previously disturbed behavior.

On the thirteenth day he was granted City Privileges in order to secure a job. There was a recurrence of some ideas of reference, on the following day after returning from a job interview, during which he had been rejected because of being a "mental patient." All symptoms subsided quickly with reassurance, although a minor "Christmas depression" was later noted upon his return from a holiday home visit. When he found a job after 24 days of hospitalization he was released.

Although subsequent appointments with the psychiatrist were not kept, his adjustment is known up to 1959. He worked only occasionally, living with his step-mother and with various friends. There were no further Court charges, nor were there further episodes of disturbed behavior.

CASE #2

This patient was a 15 year old white boy, from a broken home, in which the real father was an alcoholic, and the step-father was rejecting. At the age of six he had lost the sight of his right eye by a sling shot injury. Enuresis had continued into the early teens. His first contact with the Juvenile Court occurred at the age of eleven, when he was accused of sodomy. Six months later he set fire to two buildings. Later, after being arrested for pilfering from automobiles, he spent nine months in the Boys' Industrial

School. He was readmitted as a parole violator after a series of shoplifting incidents. The next conviction was on a charge of breaking and entering. Since he continued his homosexual activities at the Boys' Industrial School, he was transferred to the Juvenile Diagnostic Center in the Spring of 1958.

In the Center, while he was superficially cooperative and friendly, the boy had considerable difficulty in relating to people, preferring solitary activities, but he otherwise adjusted in an adequate manner, showing average ability in school. After a stay of six months he seemed to worry about his future, especially after he learned that arrangements were under way for placement with a distant relative. He showed no desire to leave the Center, a reaction contrary to that usually observed with ordinary delinquents.

One evening, as discharge plans began to materialize, he was seen falling to the floor for no apparent reason. Upon examination, no loss of consciousness was demonstrated, and he complained in a rather faint voice of an intense headache, difficulty in breathing, and general weakness. His eyes were closed and he seemed unaware of his surroundings. No signs of a convulsive disorder could be found, and a neurological examination, including an EEG later, was non-contributory. He was catatonic-like, with no spontaneous speech or movement, although when firmly questioned, incorrect and often irrelevant responses were given. These symptoms were perplexing enough so as to warrant his transfer to a hospital, where again no physical or neurological findings were found to explain the symptomatology.

The next morning, on his return to the Center, his condition seemingly was unchanged. He looked at the physician without appearing to notice him. He claimed not to know his name, the time, or place. He did not remember the examiner's name, until after a period of time. He also misidentified other objects. He appeared to be in a state of dementia, with an apparent lack of reasoning capacity. He had short episodes of auditory hallucinations, apparently talked to God, mentioning "Christ" and "salvation." His motor activity was greatly reduced, approaching at times a board-like stiffness. He disregarded or answered easy questions and simple arithmetic in a paralogical way. But he answered more difficult questions that seemed to interest him both accurately and extensively, indicating that his perceptive functions may have been unimpaired. Later, upon his recovery, amnesia for this acute episode was demonstrated. On the basis of this group of symptoms, namely disorientation, temporary dementia, paralogia, short-lived hallucinations, histrionic features and subsequent amnesia, a diagnosis of Ganser's Syndrome seemed justified.

He was assured that for the time being he would not be discharged. No other therapy or medication was given (nor was he given any medication prior to this episode). After three months he was discharged to relatives under the supervision of a probation officer by whom he was employed. However, six months later he suddenly appeared at the Center begging to be allowed to stay, claiming that he felt rejected by his relatives and the probation officer. Now he works at a sheltered workshop in the city while spending his evenings living at the Center.

Limited psychological testing was administered on four occasions. During his first confinement and three years prior to the Ganser episode his IQ was measured at 94. It fell to 77, 82, and 83 on three testings during his first and second admissions to the Center. Over the same period the Verbal IQ (Wechsler) decreased from 106 to 89 three years later. The decrease in Verbal IQ may be expected in the Ganser Syndrome since the difficulty lies in the area of verbal communication.

CASE #3

Clinical Features: This 30 year old, light-skinned Negro woman was admitted in early 1958. The theme of racial identity has overlaid her problems since childhood, when her mother insisted that she wear a large straw hat in the summertime to prevent her skin from getting brown. Following the divorce of her parents when she was six, she lived with her mother and later with grandparents. When the mother became mentally ill, the patient was placed in foster homes, where she lived from the age of 14 to 17. During this period she began to stray from social standards and had to be placed in a correctional institution. Upon escape from this institution, she married her first husband, but left him within one year because she "failed to become pregnant" immediately. Soon afterwards, she became pregnant out of wedlock. The child was rejected by her—as she had felt rejected by her own mother. Another child followed soon after her second marriage to a rather handsome, intelligent and conscientious Negro, whom she apparently married to find identification, status and security.

The patient accompanied her husband to an Army assignment in Europe. She resented the confinement of life in Army barracks and also became more and more confused upon noticing the absence of racial discrimination in the European culture. This, plus her light complexion, permitted her to live and adjust as a non-Negro outside the Army, but in barracks life, she was compelled to adjust as a Negro.

She came to the Army Dispensary on the second Christmas holiday in 1957, "confused, inappropriate, and circumstantial." Her complaint was that "I have no realization. I forget who I am. My memory writes itself for the past several months." She felt that her mind was wandering and that she "always had been two people." Hospitalization was arranged, with the admission diagnosis being "Acute Schizophrenic Reaction." She was discharged in early January 1958 with the final diagnosis of "Emotional Instability Reaction" (12). Since the precipitating cause of her illness was thought to be the stress of living in a strange culture, she and her husband were transferred back to the States.

On her return from Europe, she gradually lost interest in her family and neglected her children. When she was brought to the house of her father and stepmother, whom she resented, and was thus separated from her husband, she became more disturbed, especially at night, and "daydreamed a great deal."

Upon admission the physical and neurological examination were non-contributory. She was confused and disoriented, but remembered the date of her birth, although with difficulty. She could not recall her husband's Army station, but when the social worker casually asked her for his address she responded promptly. She said she could not recall with whom she stayed in Cleveland. However, the rest of her conversation suggested that she knew Cleveland quite well. Questions were not answered immediately but answers would appear later in the course of her rambling. Sound association was noted in her use of words, such as referring to herself as the "Royal Loyal." She thought that she was the "Queen of Sheba, the black queen," "the great future of America." Hallucinations were of short duration and seemed to be somewhat under her control since she could apparently stop them at will. Similarly, when approached firmly and on neutral topics, her behavior and thinking became at times nearly appropriate. She perceived herself as possessing a "different personality in each different country," but she said she did "not want to be anyone else, just myself like before I went to Europe." Later, upon her recovery, she could not remember any of this material.

This patient showed disorientation, anxiety, approximate and delayed responses, excitement, dissociation with changing self-identity, temporary delusional thinking and

brief episodes of hallucinations, and subsequent amnesia, all of which were in agreement with the diagnosis of a Ganser's Syndrome associated with a schizophrenic-like reaction. In addition, she had an abnormal EEG due to apparent cortical and subcortical disturbances.

Again, therapy was planned so that disturbances to the patient would be minimized. This was accomplished by isolating her for a time from her husband, children, parents, and in-laws, and by the use of Perphenazine. When she appeared to be in better and in continuous contact with reality, the husband and children, relatives and friends were gradually reintroduced into her environment. She improved slowly, during a hospitalization of three months. After her release she lived with her in-laws, whereas the children were placed with her father and step-mother in the neighborhood. Although she was advised against making any major change, she and her husband moved to a Southern state, and promptly she needed outpatient care. There, too, she showed bizarre and impersonal behavior compatible with our diagnosis of a Ganser Syndrome (9).

Psychological Findings: This patient was first tested in Germany, two weeks after her admission to the Army Hospital. Only the Wechsler-Bellevue Intelligence Scale, Form I, and the Incomplete Sentences Test were given. The examiner notes that "This subject was talkative throughout the test. She showed a tendency to have a lack of confidence in her ability to think things out for herself. When required to use her reason, she also tended to think too much on a given item and her thought processes sometimes bordered on the impractical and irrelevant; occasionally gave inferior answers before arriving at a correct one and sometimes showed little confidence in a correct choice of answer." (12) Even though the patient was deemed to be in a stage of remission, the above description of test behavior is in accord with what might be expected in a Ganser Syndrome. She is noted to have given "irrelevant" and therefore incorrect answers but because she was able to correct her answers immediately, she achieved the relatively high measured Verbal IQ of 116, Performance IQ of 111, and Full Scale IQ of 115. The Incomplete Sentence Test which mirrored her internal state of confusion was characterized by occasional pseudo-psychotic responses, *e.g.*, *Most women act*—"as though—they are acting," and *When I think back I am ashamed that*—"I was not able to give more comfort to others and give my parents joy and aid in life. Now I see that God was taking care of me and keeping me from destruction of body and soul."

The patient was given a battery of psychological tests by one of the writers shortly after her admission, at which time she would cooperate in the tests only with a nurse in attendance. Retesting was accomplished three months later, just preceding her discharge.

INTELLIGENCE TEST RESULTS (WAIS)

	Admission Testing	Testing in Remission
Verbal IQ	90	114
Performance IQ	78	98
Full Scale IQ	84	108

The time interval between the two test administrations permits a comparison of her functioning at the height of her disturbance with her normal level. The Verbal IQ initially was 24 points lower than the final testing, the Performance IQ was 20 points lower and the Full Scale IQ was 24 points lower. The greater disparity is seen in the Verbal IQ differences, as might be expected. Thus, on initial testing the patient was unable to state the direction of Panama in reference to Chicago and yet on retesting gave the precise answer, Southeast; first did not know the location of Brazil, the average height of the American woman, the capital of Italy, nor subsequent Information subtest items and on retesting gave accurate answers to these and six subsequent items.

In addition, she began the answer to an item dealing with American presidents since 1900 by responding with Washington and Lincoln, but immediately corrected herself—as was described in her test behavior in the Army hospital. In the Comprehension subtest she showed pseudo-psychotic verbalizations which, however, have some personal meaning such as interpreting a marriage license as being necessary "to avoid misuse of laws, avoid scandalous behavior." Paralogic responses were given in the Similarities subtest: when asked how air and water were alike she responded, "They are necessary to the development of green grass. They produce carbon dioxide." She began with a nearly correct answer, then digressed and lost track of the question. Lower initial scores on the Arithmetic and Digit-span sections might be attributed to confusion and lack of concentration ability. On the initial Vocabulary subtest she missed two of the easiest items, *repair* and *breakfast*, knew some of the more difficult ones, such as *encumber*, then again missed words she had actually used in conversation, *e.g.*, *audacious* and *ominous*. Surprisingly, on retesting she did not know the definition of *audacious* and *ominous* and was more consistent in her successes, passing the first twenty-nine consecutive items. The performance tests on both occasions yielded an erratic pattern but with great improvement on retesting. On the Block Design subtest she solved seven designs, and achieved a perfect score on retesting, paralleling her clinical improvement in abstract reasoning.

Projective tests, administered on both occasions, included the Rorschach Test, Word-Association Test and Draw-A-Person Test. Initially, the small number of Rorschach responses was in accord with her poor reality contact and was suggestive of subnormal mental functioning, while their content obviously suggested high level mental capacity. For example, she alluded to "Siamese twins developing growth together" (Card III). The response to Card IV, "Moth is on the tree and the bark is beginning to peel from the tree," is one of the several examples of contamination which are characteristic of acute episodes of schizophrenic-like thinking. Other responses reflected somatic preoccupation of a "hysterical" type, disguised sexual preoccupation and evidence of delusional thinking. A catatonic type of resolution of morality appeared with her concern over sin and guilt. The Rorschach retest showed a great improvement in intellectual and emotional areas of functioning with the psychotic indications nearly subsiding. The initial Word Association Test responses were pedantic, grandiose, and indicative of paralogia and psychotic thinking. For example, the association to the stimulus word *drink* was "you must have water to drink tea", which suggests that she was attempting to give the usual response, water, but instead talked "beside the point." To the stimulus word *mountain* she answered, "A very large thing you see that goes up in the air," suggesting that the stimulus word was assimilated, though answered in an indirect fashion. On the other hand, the Word Association retest responses were clear and appropriate single-word responses. The Draw-A-Person Test results initially suggested evasion and malingering, especially in her drawing of the examiner, which was not the case on retesting.

DISCUSSION

Situational factors and secondary gain: One of the most fundamental characteristics of our culture is the principle of freedom. Restriction of freedom by imprisonment, Army regulations or other means, is usually considered undesirable, and produces discontent and desire for release. For a few people, however, an environment restrictive of freedom may have certain advantages over independent life in the cold, competitive, and often dangerous outside world. Nowadays a prisoner is actually guaranteed many of the gratifications for which the average individual may have to strive. A prisoner is housed,

clothed and fed; he is protected from outside dangers; and he has a certain degree of security. It is conceivable that the advantages of institutionalization are sought for, unconsciously, by some of the inmates. For these people, leaving such a protected situation may present more of a problem than entering it. It is common knowledge that this also holds true in other enforced group-living situations. For example, flare-ups in the symptomatology of long-term psychiatric patients being considered for discharge are not infrequent. The *secondary gain* accruing from this sheltered existence is precisely what may make their adjustment in the hospital possible.

The three patients here reported all exhibited disturbance when the risk of losing a protective and secure environment occurred, because this environment may have been one of the conditions necessary for their appropriate functioning. In other words, the situational factor is the *locus minoris resistentiae* in the chain of events necessary for this reaction to occur. The culture in which one lives may also satisfy the need for security, and Case #3 clearly demonstrates that "alienation from culture" (6) may precipitate a psychiatric disorder. Similar adaptive difficulties were experienced by minority groups in cultural isolation, as described by Koranyi (5).

The literature stresses the occurrence of the Ganser Syndrome upon entering a potentially difficult situation. Our report demonstrates that *leaving a protective environment* may produce the same syndrome as well.

Problems in identification: The need for a certain environment may be viewed as a specialized expression of perhaps a universal human dilemma, a conflict between aggressive self-assertive impulses and passive dependency. For some, the threat of being left out by the group, with the consequent necessity of having to face external problems, coupled with the general feeling of not knowing what to do, where to go, or what standards to "hold by," may create panic and confusion.

Lack of stable and enduring identification figures, such as mother, father, or family, led all three patients described to an attempt at identification with institutions or cultural norms. The third patient seemingly had resolved the conflict by becoming the wife of a Negro soldier. In the United States, although as a Negro her freedom was restricted, she obtained some measure of security from the boundaries set by the American social and racial structure. Her frame of reference faded away in the post-war European atmosphere where she was not identified as a Negro because of her light complexion. On the other hand, within the Army setting, she was subjected to certain racial and cultural restrictions. The same situation existed when she later moved to the South from Cleveland.

Clinical symptoms: Hysterical and schizoid traits were apparent in the pre-morbid personality of all three patients. A *sociopathic component* appears in the form of suspected malingering for secondary gain or as a perhaps unconscious planning directed for some deliberate intention. Two of the three patients had clearly antisocial records, and the third had shown great impairment in intersocial relationships.

The physical and mental status is characterized by anxious agitation (even to the point of panic), confusion, disturbance in motility ranging from dazed stupor to hysterical excitement, all of which is apparent in somatic motor activity, speech, and thought process. The latter may be disturbed to the point of *episodic delusions and hallucinations*, that are not definitely schizophrenic in nature.

The apparent dementia is relative, incomplete, and temporary, absurd and childish in character (*pseudo-dementia*). The *amnesia* for the acute episodes, seen later, may be related to this pseudo-dementia.

Object relationship is not completely lost, but the object is "missed," perhaps in part

by intention, and misinterpretations are common. The same difficulty in object relationship appears in the demonstrated symptom of *Paralogia* (Vorbeireden). The alternate term for the Ganser Syndrome, "Syndrome of Approximate Answers," emphasizes the diagnostic importance of *talking beside the point*. In addition to this typical symptomatology, the acute onset of this disorder under the impact of a stressful situation, the gradual vanishing of the symptoms, the intermittent character of the psychotic component, if it exists, the limited duration, and the subsequent amnesia, all are of diagnostic importance.

Psychological criteria: Psychological reports of cases of Ganser Syndrome appear to be relatively few. We know of only one detailed case, that presented by Goldin and Macdonald (4). In this case, however, the intelligence quotient was below 70, with no report of a re-test following remission. Nevertheless, the pseudo-dementia was recognizable. The present series of cases includes an adolescent whose measured IQ showed a decrease from 94 to 84 (Full Scale Wechsler). Another female patient was tested on three different occasions, the first time in Germany, the second while acutely ill and the final testing when she was again in good contact with reality. Her test scores were also significantly lower while she was disturbed, which may again typify the clinical pseudo-dementia. From these limited findings we would emphasize the diagnostic importance of intelligence test results. The deficit in intellectual functioning is of a temporary nature, as is the rather erratic pattern of successes and failures on the subtests. Paralogia is evidenced in the patients' responses to both intelligence and projective instruments. The latter also demonstrate a pseudo-psychotic response picture, in that atypical psychotic responses are given. Hysterical personality components are found, as well as some evidence of malingering.

The crucial factor in psychological confirmation of the diagnosis appears to be the *test-retest comparisons* when the above features and schizophrenic-like content subside with the patient's remission.

Dilemma of classification: There is considerable disagreement as to the proper classification of the Ganser Syndrome. Does it fall into the group of "hysterical" psychoneurotic conversion reactions, is it a psychosis, is it simple malingering, or is it a situational stress reaction? A detailed discussion of this topic is found in Weiner's contribution (8). Clinically, the Ganser Syndrome is a peculiar and unique combination of the possibilities mentioned. Evidently it can appear superimposed upon other psychiatric disease processes.

Several other clinical pictures show a certain resemblance to this syndrome: the paranoid reactions in the deaf, the transient psychotic states following ophthalmic surgery when vision is temporarily obscured, the "transient psychoses of linguistically isolated persons" (1), the psychotic reactions due to increase or decrease of meaningful stimulation outside an individuals' range of tolerance (11), such as arctic explorers, solitary ocean sailors, or in isolation chambers. Perhaps these reactions ought to be classified together as "Reaction twilight states" (7) or as *transient psychotic states associated with situational factors or with variations in stimulation.* Kretschmer's "Primitive Reaction" has in common with the Ganser Syndrome, the reflex-like ineffective response of the individual before the situation has been actually fully grasped.

Interestingly enough, Dobrzhanskaia (2) recently has described a similar "reactive condition with excitement phenomena" seen mostly in forensic psychiatry and possibly corresponding to the diagnostic term, Ganser Syndrome. She stresses evidence for sympathetic-adrenal and other vegetative dysfunction. Certainly the temporary confusion, disorientation, pseudo-dementia, and the brief pseudo-psychotic features are compatible with a, perhaps secondary, organic-chemical malfunctioning.

Therapy: With a knowledge of only one of the etiological factors involved, the situational factor, therapy may be focused on this factor. As most literature and our three cases reports suggest, a change towards a better-structured and more stable environment leads to a decrease in subjective uncertainty and anxiety. Thereupon, the integrating forces of the individual are usually strong enough to end the episode. Environmental manipulation should be aimed at initiating interest and meaningful participation by the patient on his own behalf. The importance of the situational factor may also diminish when the patient becomes more familiar with a dangerous situation and thus is able to cope with it. Interpretations should be given at a non-verbal level, in the attitudes and actions of the therapeutic team.

When a Ganser Syndrome is superimposed, say, upon a beginning schizophrenic reaction, early chemical tranquilization seems indicated in order to avoid potentiation and fixation of psychotic thinking and functioning.

Usually the prognosis is good. Recurrence of this syndrome in a later similar situation can be prevented simply by allowing the patient to know and feel that no need exists for him to react in such a fashion again.

SUMMARY

Three cases of Ganser Syndrome are presented, including reports of a psychological examination given one patient. In the cases presented, the syndrome is described in connection with a restricting but protective life situation which is perceived by the patient as being preferable to the hazards of freedom. Acute symptoms were here precipitated, contrary to former reports, by the threat of expulsion from the first type of environment into the second.

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A CASE OF GILLES DE LA TOURETTE'S DISEASE (MALADIE DES TICS): A STUDY OF THE INTRAFAMILY DYNAMICS[1]

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INTRODUCTION

Gilles de la Tourette's Disease (Maladie des Tics), first described in 1885, has remained a psychiatric enigma. It is described as a syndrome appearing at approximately ten years of age, characterized by tics of the head, limbs, or body, associated with varying abnormalities of speech progressing to coprolalia with associated echopraxia and echolalia (5). Although both organic (6) and psychogenic etiologies (3) have been postulated, these opposing theories remain unproved. Ascher (1) described five cases with a discussion of the psychodynamic factors involved. Brief description of the parents of these patients were given but precise psychiatric evaluations of them were absent. Kanner *et al.* (2) contributed to the literature seven cases studied at his clinic with brief discussions of the interpersonal factors involved. However, detailed psychological evaluations of the parents' personalities were also lacking in this study.

This is the report on a case of Gilles de la Tourette's Disease in which psychological evaluation was made of both parents as well as of the patient. Detailed personal histories were obtained from the parents and, in addition, both were given the Wechsler-Bellevue Intelligence Scale, the Rorschach Psychodiagnostic Test, the Thematic Apperception Test and the Minnesota Multiphasic Personality Inventory. The interaction between the patient and the parents, based on the needs of the parents, will be discussed as determined by the findings of psychological tests and observations in joint interview settings. The initial workup involved approximately 15 hours of interviews and testing with the patient and each of his parents.

CASE STUDY

Peter G. L., a 12 year old boy, was referred for psychiatric evaluation as a differential diagnostic problem. The initial pediatric impression had been Sydenham's chorea. However, lack of a typical recent streptococcal infection had raised doubts about this possible diagnosis. The present illness developed during the first week in March of 1959. The presenting complaints were marked facial grimacing, blinking, and twisting movements of the face and neck. This was associated with paroxysms of guttural noises. Peter would whistle, grunt, bark, or repeat phrases such as "ha-ha-ha," and these would break into his normal stream of conversation. It was noted that he tended to repeat statements over and over.

The parents described Peter as a high-strung youth who tended to become anxious and "fidgety" whenever he had physical complaints, and would pick compulsively at sores. He had always been an obsessive questioner, a habit which his parents found irritating. The patient had an episode of facial spasms two years previously and coincident with the birth of the youngest male member of the family, which took the form of repetitious blinking and neck stretching, and this behavior continues to the present. At the onset of these symptoms, the patient's mother had been ill for approximately

[1] This study was carried out at the 2500 USAF Hospital, Mitchell Air Force Base, Hempstead, Long Island, New York.

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two weeks, during which time the father cared for the family. Prior to this, the mother had never been ill. The father insisted upon rigid discipline, and made many demands on Peter, who routinely assumed many household chores.

Because of the uncontrollable nature of Peter's noise-making he became an object of ridicule among his classmates, and one of concern and vexation to his teachers. Two weeks later, Peter was taken out of school and remained at home until seen in this clinic. On the day that he first began to make the "ha-ha-ha" noises, he was slapped by his father each time this occurred. When the father realized that Peter could not control the noises, he felt extremely guilty and bought Peter a toy gun. During the onset of the symptoms, much anxiety was created in the family because Peter expressed a desire to spend some of his earnings on a toy gun and a hunting knife. This was strictly prohibited by the father who felt it was an early manifestation of delinquent tendencies.

Peter has always been an extremely meticulous child in the home and has been expected to excel in general behavior and in academic work. However, it is reported that Peter's younger brother, who is eight years old, has always been praised for achievements, the calibre of which would have won criticism for Peter.

Peter wet the bed to the age of four, stopped for one year, again began at five (this was coincidental with a move made by the family), and then stopped spontaneously at seven. He has been a chronic nail-biter since early childhood.

At 18 months, the patient broke his collarbone. There is a history of repeated tonsillitis from the age two and one-half until eight, at which time Peter underwent a tonsillectomy. He has had measles, mumps, and chickenpox with no obvious complications or sequelae. At six, Peter received a large scalp hematoma with no evidence of intracranial damage.

Physical examination was within normal limits except for the obvious tic-like movements and speech apparitions previously described.

Laboratory examinations included CBC, UA, spinal tap, EEG, EKG, antistreptolysin titre, C-reactive protein, sedimentation rate, skull and chest x-rays: these were all within normal limits.

PSYCHOLOGICAL EVALUATION

Psychological examinations administered included the Rorschach Psychodiagnostic, the Stanford-Binet Intelligence Scale and the Thematic Apperception Test. On the Stanford-Binet Peter achieved an IQ of 130, indicating a superior level of intelligence. The projective tests suggest the presence of extremely rigid emotional controls. These data suggest that Peter's compulsive sounds and movements are a method of self-punishment, and are related to feelings of hostility and guilt toward authority figures.

PARENTAL EVALUATION

The patient's mother, now 37, has been married for 15 years. She is the second oldest of three siblings. Her description of both her parents, while colorless, was positive and generally indicative of a good relationship. There have been no illnesses within her family similar to Peter's present affliction. When Mrs. L. was first interviewed, it was noted that she spoke with considerable pressure and repeatedly made "uh"-like noises. She was extremely anxious and appeared to be on the brink of tears. Mrs. L.'s attitude toward Peter suggests anxiety, confusion, rejection and guilt. She has been extremely perfectionistic with the child, subtly extracting high levels of performance and making ever-increasing demands upon him. This attitude is in sharp contrast to that displayed toward Peter's younger brother, whose academic achievements are inferior and who does considerably less around the

home. Mrs. L. recognizes this attitudinal discrepancy and has many guilt feelings about it, yet she feels incapable of changing her behavior vis-a-vis the siblings. Psychological evaluation yielded an IQ on the Wechsler-Bellevue Intelligence Scale of 123, with a relatively consistent pattern in subtest performance. Projective data showed a person of high intellectual capacity performing at a much lower level than her potential. Extreme feelings of inadequacy and strong repression of emotions appear to combine to produce Mrs. L.'s rigid behavior. Perfectionistic needs are not satisfied, and failure is concomitant with anxiety and feelings of inadequacy.

In interview the father was noticeably anxious and uncomfortable. His appearance was notable both because of frequent eye blinking during conversation and because of his extremely compulsive behavior. He is the third oldest of seven siblings. Mr. L. has had a facial tic since his youngest years. His brother, two years older, is reported to have a facial tic and a repeated pattern of neck stretching. His relationship to his wife is one of extreme dependence; he looks to her for many decisions and is resentful and ambivalent if the support is not found. Bewilderment and inconsistency characterize his attitude toward Peter. He appears to be unsure of himself as a father and his conceptions of what should be expected of a boy are suggestive of those of a probation officer. His bewilderment is exemplified by his fear that Peter may become a child delinquent if allowed to purchase toy guns or hunting knives. Psychological evaluation revealed Mr. L. to be a highly intelligent individual, having a full-scale IQ on the Wechsler-Bellevue Intelligence Scale of 130 with little interscore scatter. Projective testing indicated that Mr. L. has developed elaborate defenses against possible acting out. His rigidity may be a conversion of basic aggressive impulsiveness based on fear of making the wrong decision. Ambivalence is manifested in many spheres with resultant anxiety and strong feelings of inadequacy.

INTRAFAMILY DYNAMICS

The parents' relationship, although lacking in overtly hostile behavior, clearly is not particularly satisfactory to either. Because of their own feelings of inadequacy and insecurity they are not able to satisfy the other's longings for a dependent relationship. It is believed that the patient's birth was fancied as the answer to their previously unsatisfactory relationship: when it did not improve with his birth, Peter became the object of their hostilities. The boy's presence did not work the hoped-for change; more, Peter compounded the problem by limiting his mother's freedom and became a rival to the father for the mother's time and affection. The parents have controlled their ambivalence toward each other and have singled Peter out as their object of hostility. They are entirely conscious of this and although they experience considerable guilt feelings about their behavior toward him, they are unable to control it. Peter recognizes the inconsistencies in his parents' attitude toward himself and toward his younger brother. His resentment and anger over this periodically presents itself and is utilized as a justification by the parents for their perfectionistic demands and punitive attitudes. At times they have attempted to control this hostility, *e.g.*, by asking for counselling on how to handle situations which arise (such as Peter wanting to stay up beyond his bedtime).

The birth of the youngest sibling is reported to have been especially stressful to the patient. He felt, in effect, that the love he had obtained through hard work might now be given to another. At the time of the onset of the present symptoms, the father's anxiety and insecurity, perhaps due to the mother's illness, had mounted to a level previously unexperienced by the child. The increased demands thus placed on him

had broken down his already brittle controls and seemingly resulted in the present behavior. The mother seems now to function at the level of a compulsive personality with moderate fluctuations in her omnipresent anxiety. Mr. L.'s defenses seem less adequate than his wife's; an obsessive-compulsive neurosis appears now to be present, although he also manifests depressive symptoms. Because of the precarious adjustment of both mother and father, it is suggested that a change in Peter's role in the family might result in further incapacity of either or both parents.

COURSE OF ILLNESS

Both psychotherapeutic and pharmacotherapeutic interventions have been instituted in the care of Peter. He was initially placed on Equanil, one 400 mg. three times a day, and this resulted in initial improvement of his symptoms. However, after six weeks the symptomatic manifestations were still grossly evident and only slightly modified by this therapeutic regime. In May, the patient was started on Artane and, over a six week period, the medication was built up to a level of 16 mg. a day. This in no way seemed to alter Peter's symptomatology. The Artane was decreased to 8 mg. a day and was combined with Meprobamate, one 400 mg. four times a day. This combination also proved ineffective in altering the patient's symptomatology. Following a six week trial on Artane-Meprobamate therapy, the Meprobamate was discontinued and Artane, 8 mg. a day was combined with Kermadrin, 10 mg. a day, and Dexedrine, 15 mg. a day. This combination has not altered the symptomatology. In fact, during this period, an intensification appeared. Following the initial workup, both Peter and his mother were seen in psychotherapeutic interview once to twice weekly, amounting to a total of 30 interviews each. A therapeutic goal, in working with the patient, has been to enable him to express some of his feelings of hostility and frustration in relation to his parents. This has been only moderately successful. In interviews with the parents an attempt has been made to alter some of the psychopathological attitudes as brought out in the presentation. However, this again has only been moderately successful. To date, no basic alteration in the symptomatology of the illness has been effected.

DISCUSSION

At present, there is no unequivocal indication that any therapeutic regime alters the natural course of the symptom complex described as Maladie des Tics. As the etiological factors remain a matter of speculation all therapies that are instituted are of purely empirical basis. Fenichel (3) describes this syndrome as a pregenital conversion and makes the magnitude of therapy comparable to that of speech disorders and tics. At this level the psychopathology is great and the psychotherapeutic successes are few. It has not been shown that any specific therapy alters the natural course of this syndrome, with its generally grim outcome (7). The case described by Kanner (2), followed over an extended period, seemed to indicate that psychotherapy favorably altered the natural course of the disease. This position has been recently challenged by Rapoport (4), who presented two cases to show that psychotherapy did not alter the symptom complex, and that pharmacotherapeutic measures had been effective. The present case study, which has employed all of the pharmacotherapeutic agents used by Rapoport, would tend to minimize the usefulness of these agents in this symptom complex. The natural course of this disease, which like so many psychiatric illnesses shows periods of exacerbation and remission, makes the evaluation of any therapeutic regime on a small series of cases extremely suspect. Hereditary-organic predisposition as opposed to environment ge-

netic factors have been the subject of recent controversy and speculation in the literature (2, 4). The interpersonal interaction as brought out in this case study would seem to explain adequately—on a genetic dynamic basis—the reasons for evolution of this symptom complex. The father's and uncle's tic-like movements combined with the mother's predisposition toward stuttering and speech aberration might be used as suggestive evidence of hereditary predisposition. However, the psychodynamic mechanisms of identification could also explain the patient's adopting these mechanisms to express his conflict. Although other detailed case studies are certainly needed to add support to the evaluation of these factors, it is felt that at least in this one case study, organic factors were less important than psychopathological reactions to environment stress.

SUMMARY

A case study of Gilles de la Tourette's Disease was presented in a twelve year old boy demonstrating neck and facial tics, coprolalia and echolalia.

Psychiatric and psychological evaluations of the patient, his parents, and their interaction was described.

It was felt in this case that the psychopathological reaction to environmental stress was of greater etiological importance to the development of the syndrome than organic factors.

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BOOK REVIEWS

RINKEL, MAX AND DENBER, HERMAN C. B., EDS. *Chemical Concepts of Psychosis.* McDowell, Obolensky, New York, 1958. xxi + 485 pp., illus., $7.50

The exciting discoveries of the past decade in the fields of neuropharmacology and neurochemistry have undoubtedly had a great impact on psychiatric thinking. The honeymoon of psychiatrist and biochemist is being celebrated in numerous meetings, conferences and symposia. The present volume is a record of thirty-six papers presented at a symposium held during the Second International Congress of Psychiatry at Zurich in September, 1957.

The book opens with a historical review by Osmond which is equally remarkable for its scholarship and readability. The following chapters deal with the chemistry, metabolism and pharmacology of hallucinogenic drugs starting with the early bulbocapnine experiments of Baruk and going on to more recent work on lysergic acid diethylamide (LSD), mescaline, adrenochrome and other indole compounds. Evarts describes the effects of LSD and bufotenin in monkeys and shows that both drugs specifically depress the postsynaptic response of the lateral geniculate body to optic nerve stimulation after intracarotid injection in cats. Cerletti emphasizes the lack of correlation between peripheral antiserotonin effects and hallucinogenic properties in LSD and its congeners and Hofmann shows the absolute specificity of the steric configuration of LSD for its hallucinogenic effects. Thuillier finds that LSD in small doses is a potentiator of serotonin, in common with other hallucinogenic drugs. Block reports on his observation that mescaline and other amines are incorporated into tissue proteins and that the process is counteracted by an anti-incorporation enzyme. Hoffer presents his hypothesis on the role of adrenochrome and adrenolutine in the genesis of schizophrenia. He points out that, in contrast to mescaline and LSD, adrenochrome and adrenolutine produce changes in personality and thought with minimal perceptual visual changes.

The pharmacology of serotonin with particular reference to the nervous system is competently reviewed by Twarog. The suggestion that a deficiency of serotonin in the brain may be responsible for psychosis is proposed by Woolley, while Bulle favors the view that there is an excess of cerebral serotonin in schizophrenia. In two papers differences in the excretion pattern of indolic substances in the urine of schizophrenic and normal subjects are described.

Marrazzi gives an account of the inhibition of transcallosal synaptic transmission by LSD, serotonin and other compounds and its reversal by tranquilizers. The mechanism of action of tranquilizers in relation to neurohumors is discussed by Brodie who suggests that reserpine acts by stimulating the trophotropic centers, and chlorpromazine by inhibiting the ergotropic centers in the midbrain. The effects of intraventricular administration of drugs are described by Feldberg in a stimulating article.

Another series of articles deals with the biological effects of body fluids from schizophrenic subjects. Heath presents his exciting and controversial results with taraxein while Winter describes the effects of urine and plasma samples from schizophrenics in the rat-climbing test, which led him to the conclusion that "there is no doubt that biologically active substances are present in the blood and urine of at least the majority of schizophrenic patients and absent in most nonpsychotic subjects." On the other hand, McDonald produces evidence that the increased activity of ceruloplasmin in schizophrenic plasma is unspecific and related to low levels of ascorbic acid.

Finally, a number of authors present pa-

pers on the clinical and psychological effects of hallucinogenic and tranquilizing drugs, on the nature of the schizophrenic process and on problems of clinical research. The book ends with a summary by Gilbert Cant.

To the non-specialist or the newcomer this book may serve as a valuable introduction and a balanced survey of the field. The expert will find it stimulating reading and a useful source of reference. There will be aspects about which he will not feel entirely happy and opinions with which he will disagree. As Kety has recently pointed out, many of the positive biochemical findings in schizophrenia may sooner or later be matched by negative results when various extraneous factors are more rigorously controlled. The thorny question of controls is aptly discussed in the book by Kline. There is moreover the question of specificity about which one would like to know more; how specific, for instance, is the effect of serotonin on brain cells in tissue culture? The inhibitory effects on transcallosal synaptic transmission studied by Marrazzi impress one by their lack of specificity and the scale of relative potencies does not mean much so long as the concentrations at the site of action are unknown. One feels that for the electrophysiological study of neurohumors techniques will have to be developed on a cellular level.

One result of the recent plethora of symposia is the phenomenon that certain hypotheses have attained the status of facts, not by the increasing weight of evidence but merely by dint of constant repetition. The process goes somewhat as follows: Let us suppose A writes, "On the basis of our spectroscopic observations the suggestion may be tentatively put forward that the moon is made of green cheese." Author B in his review of the field states, "A has provided strong evidence in support of the theory that the moon is made of green cheese." Author C, who probably has read B but not A, then says, "As has been shown by A, the moon is made of green cheese," and author D's version is, "It is now generally accepted, that etc."

An example of this kind of process is seen in the repeated reference to adrenochrome and adrenolutine as metabolites of adrenaline. Derivatives they assuredly are, but whether they are metabolites has not yet been demonstrated to the satisfaction of most investigators.

On no less than four occasions the reviewer has found the expression "adrenaline cycle" (or "epinephrine cycle"). To the biochemist a cycle suggests a sequence of reactions in which a molecule is broken down and resynthesized in such a way that some or all of the breakdown products are utilized in the synthetic reaction. Thus it would be perfectly legitimate to speak of an acetylcholine cycle, but as for an adrenaline cycle, there simply is no such thing.

In the formula for neuraminic acid on page 295 two members of the ring are shown as such (correctly), two are shown as side chains (incorrectly), and two are shown as both!

In spite of these minor reservations, the book may be thoroughly recommended.

H. Weil-Malherbe

KRETSCHMER, WOLFGANG, JR. *Selbsterkenntnis und Willensbildung im ärztlichen Raume.* Georg Thieme Verlag, Stuttgart, 1958. vii + 146 pp. $4.65

Since the end of World War II, German psychiatrists have shown remarkable interest in the theory, the practice and the teaching of psychotherapy. Oddly enough, in this field they are not burdened by its history of the last 60 years, and therefore seem to be quite open to new and experimental ways. This book is an outstanding example of this general and somewhat bewildering attitude, this groping for new therapeutic avenues. In the author's opinion such methods can only arise from fresh assumptions based on the most general and fundamental reflection on man, illness and therapy. On his road to such reflection he is carried back to Chinese

and Indian philosophy, to Christian mysticism, "the mother of depth-psychology," and to the era of Goethe with its classicism, romanticism and idealistic philosophy. These sources of three thousand years of psychological intuition and spiritual guidance lead away from the psychotherapeutic systems which "in the past 50 years have grown on the positivistic tree of the 20th century"; they are pointing away from an analytical at a synthetic psychotherapy.

The central problem of the modern concept of neuroses is the myth, as "the consciousness-transcending matrix of the psychic life, the soil and ground of man's being." Knowledge of religion also is important for the psychiatrist, who ought to search for and make use of its general principles, yet must refrain from any confessional pretensions. Indeed, Doctor Kretschmer sees the timeless roots and the future of psychotherapy only in a genuine mysticism and a genuine pedagogy. By mysticism (Mystik) he means the exacting as well as the loving communing with "thing, man and God," and the understanding of their being. Pedagogy is the harmonious unfolding of the will nurtured by this understanding of being and leading to it. Will is the most original phenomenon of life, its working principle, not just the conscious mental activity. Kretschmer takes great pains to lay down the theoretical foundation for his therapeutic technique since "one simply can not separate the one from the other." In developing or taking over a definite psychotherapeutic technique, the psychiatrist implicitly and inevitably professes his own beliefs. Psychotherapy is not a technique, but contains it.

The analytical approach is primarily concerned with the patient's symptoms and their development; the synthetic way sees the sick man before the background of his positive potentialities. Considering the three basic formative factors of man, *i.e.*, natural growth and development, freedom, social-cultural life, the therapist asks, how the individual patient relates himself to these fields of forces (analysis) and how can he be rooted best in them (synthesis). Synthetic therapy then comprises two main avenues of approach: the contemplative-gnostic way, which trains the imagination and the intuition of existential factors and values; and the voluntaristic way, which intends to develop the creative powers of the will, by attacking the conative disturbance directly. The crowning feature of this psychotherapy is the use of meditation directed at the patient's inner life in its totality, and embracing the individual's hierarchical structure according to the physiological, psychological and anthropological aspects. The author discusses in some detail different meditative techniques and the way in which hypnosis, autogenic training, waking suggestion, training of breathing and gymnastic exercises are employed in order to intensify body-awareness as well as to stimulate and direct the "Unconscious." Due credit is given here the related studies of Milton E. Erickson, Harold Rosen, C. G. Jung, I. H. Schultz, Carl Happich, H. Leuner, R. Désoille and Friedrich Mauz.

In contrast to the free association of psychoanalysis the meditative-voluntaristic therapy is characterized by the goal-directed and directing attitude of physician and patient. At present, Kretschmer is working with a third therapeutic approach, the guided occupation with that kind of authentic myth, which is found in the Bible and in fairy tales. In reading and retelling such myths, the patient, partly unconsciously and partly in discussion, comes upon the archsymbols of "being" and "becoming." The task of this method is to find intuitively the patient's specific myth and to develop it as a giver of meaning to his life and of strength to live it. Psychotherapy can only be understood as a dialectical process, in which personal-mythical intuition and analytical reflexion, spontaneous action and deliberate technique compensate each other fruitfully. Yet, the primacy belongs

to intuition. This book contains much criticism of psychoanalysis, but "the synthetic psychotherapy remains indebted to psychoanalysis for many psychological observations and details. We cannot undo discoveries and insights gained but must sift and order them."

This work is no easy reading. There are repetitions, trivialities, sloppy sentences, but also excellent formulations and dithyrambic passages. Yet it breathes provocative freshness, conviction and zeal. It even contains more practical hints and more common sense than its impregnation with metaphysics, aesthetics and religion might lead one to expect.

W. O. Jahrreiss

KARNOSH, LOUIS J. AND MERENESS, DOROTHY. *Psychiatry for Nurses.* 5th ed. C. V. Mosby Co., St. Louis, 1958. 406 pp., illus. $4.50

The preface and introductory chapters to the fifth edition of this text offer promise of the role of the psychiatric nurse as a therapeutist. The authors state the role as including understanding, support, and guidance as well as helping the patient achieve independence and self-direction. However, this frame of reference is not developed in succeeding chapters. The presentation instead reverts to the orthodox classification of mentally ill patients and the handling of patients with some degree of understanding. This understanding is based upon seeing the patient in light of the psychotic reaction or disease. The interpersonal interaction process between nurse and patient that makes for the therapeutic role of the nurse, is not discussed at any length.

The reviewer was favorably impressed with the chapter on Psychopharmacology, which includes the tranquilizers. This chapter is an addition to previous editions. The revised reference lists will also be helpful to the students of psychiatric nursing.

ALTSCHUL, A. *Aids to Psychiatric Nursing.* The Williams and Wilkins Co., Baltimore, 1957. xii + 281 pp. $2.50

The textbook, which is one of a series, highlights in simple language some of the overall themes of psychiatric nursing care. It is an excellent guide for student nurses. Educators of nursing will also find this text useful and meaningful as a teaching tool for classroom discussions.

The author has been able to communicate her experiences in psychiatric nursing with understanding and sincerity. The simplicity in her writing is an asset to understanding the text.

In addition to the problem areas involved in giving psychiatric nursing care the author has included a chapter on the care of emotionally disturbed children. The last part of the text deals with psychiatric treatments including the somatic therapies, the use of drugs, and psychotherapy. These treatments are well explained, although the chapter on drug treatment does not deal with the tranquilizers to any extent. The list of references includes both American and English literature.

The book is recommended for beginners in psychiatric nursing who are interested in giving care to the patient, and not the psychotic reaction. It implies an interaction process between nurse and patient in relation to the environment.

Marguerite Termini

GETZ, STEVEN B. AND REES, ELIZABETH L. *The Mentally Ill Child: A Guide for Parents.* Charles C Thomas, Springfield, Ill., 1957. xiv + 88 pp. $3.50

A school psychologist and a pediatrician (the mother of a mentally ill child) have written this little 88-page book to help parents of mentally ill children to understand the need for differential diagnostic procedures, the nature of the behavior of the child and the parents' own attitudes, and to guide them in the management of the

child at home and/or in the planning for institutional care.

This reviewer feels that the dictum, "little knowledge is worse than none," applies to the usefulness of this book. It does not impart real knowledge—it is not intended as a text book—but brings sketchy bits of information which may be just enough to increase the anxiety of many parents and may lead to comparisons and conclusions with regard to their own child which can only be confusing.

Fourteen observations of the behavior of the reported single case are in themselves not characteristic of mental illness and can be of diagnostic value only as part of the total evaluation of the case. As single observations they can be found in most healthy children. What the distressed and worried parent will do with this list of "observations," *i.e.* symptoms, will be a reflection of the degree of his anxiety and the liveliness of his imagination but will have no value for clarifying the condition of his child. Just as the symptoms of the patient have to be evaluated by an objective expert in the field, the facilities of the community services available, as applied to a particular patient, must be judged by a neutral observer who is familiar with the case and the facilities as they vary from state to state, and from year to year within the same community.

The chapter entitled "The Need to be Cautious" is apt—in the opinion of this reviewer—to increase parents' suspicion and resistance to institutional care. The "selected bibliography" which is listed "as reference for the material presented in this book" is not indexed in the text and is not arranged according to topics so as to fulfill the second stated purpose, "to point out to parents the many different types of research."

ROBERTSON, JAMES. *Young Children in Hospitals.* Basic Books, Inc., New York, 1959. xiv + 136 pp. $3.00

The author, a British psychoanalyst, is an authority in the field of maternal deprivation and known to the medical and nursing profession by his publications and the film, "A Two Year Old Goes to the Hospital." The book contains important information for physicians, nurses, hospital administrators and interested lay groups such as nurses aides, hospital volunteers or even individual parents who are faced with the problem of hospitalizing one of their own children. The text of 136 pages is written in a readable style with a minimum of professional jargon. The list of 55 references, although not exhausting the field, is helpful to those who wish to study the subject further. The content of the book should be part of the basic training of all those concerned with the care of children away from their parents, including personnel of orphanages, "baby homes," all-day nurseries and social agencies in general.

Dealing mainly with children up to four years of age, the author emphasizes the serious traumatic effect which separation has upon the young child and how hospital staff and parents can help to alleviate this trauma and prevent possible lasting emotional damage. He pleads for living-in arrangements for mothers or unrestricted visiting hours. The effects of short- and long-term hospitalization upon the small child are discussed in separate chapters; various systems of nursing care are described and respective advantages pointed out. Three cases, representing short, medium and long term hospitalization, are briefly described and the children's behavior in the ward and after discharge is discussed.

This book is recommended without reservation as an excellent guide in the field of emotional aspects of hospitalization.

LIEBMAN, SAMUEL, ED. *Emotional Problems of Childhood.* J. B. Lippincott Co., Philadelphia, 1958. viii + 176 pp. $5.00

This is a compilation of material pre-

sented at a lecture series at the North Shore Hospital in Winnetka, Illinois. The content is presented in clear, non-technical language. The book is intended to make practical contributions to the medical practitioner in helping him in the recognition and management of emotional problems in everyday practice.

Pregnancy and parent-child relationships are described and discussed by T. Benedek, a psychoanalyst. The chapter portrays the specific roles of mother and father in the family triangle and emphasizes the interaction between the members of a family, each one influencing and ultimately modifying the attitudes of the other. The author points out how each additional child finds a modified and different home situation from his older siblings. Parents relive in their children their own emotional experiences, find solutions for their conflicts and grow up with their children. The author's emphasis on hormonal and innate instinctual determinants for behavior patterns is at variance with the point of view of others who have shown that cultural and environmental factors are of greater significance.

Feeding, sleep and motility patterns are discussed by J. B. Richmond and E. L. Lipton, pediatricians with an analytic orientation toward emotional problems. This article should be most helpful to the practitioner in understanding common disturbances which frequently harrass parents and puzzle physicians. The authors emphasize the need for parental evaluation in sleep and feeding disturbances as they are usually caused by maternal attitudes, misconceptions or inner conflicts. The 19 references are a good source for further study and the problems and questions raised by the authors stimulate further thinking and research in this area of early child development.

Medical education often does not prepare the physician to deal with disorders of human functioning which are usually treated by other disciplines. Nevertheless it is the physician who is most often called upon to recognize and evaluate their seriousness and to direct the parents to the proper sources for help. Among such problem areas are speech disorders and learning difficulties which are systematically though briefly discussed by M. H. Powers, a psychologist with the Board of Education in Chicago.

The chapters on "Social Maladjustment and Misbehavior in Childhood" (H. M. Segenreich) and on "Puberty and Sex in Adolescence" (M. A. Sklansky), both written by psychoanalysts, present a brief but clear and easily understandable outline of psycho-sexual development and some basic psychoanalytic concepts. In the first article some of the more common disturbances in childhood, their dynamic background and suggestions for their management are presented. The second article is limited to the explanations of conflictual feelings and situations in the adolescent period.

Behavior disturbances during adolescence are discussed by J. B. Cramer, a child psychiatrist who has developed a nearly unique treatment approach to these problems. His contact with the child is limited, with the emphasis on counseling and advising the mother. At the onset the interviews with her are frequent; later they become widely spaced, with occasional telephone contacts. Thus he can evaluate at each interview the effect of his counsel given at the last session and offer "his assistant," the mother, the opportunity to practice for several weeks. This kind of approach may well be usable for the dynamically oriented non-psychiatrist as well.

The lecture on juvenile delinquency, by J. J. Michaels, is a review of the literature (45 references) and a critical evaluation of the subject, taking into account the views of anthropology, sociology, psychiatry and psychoanalysis. A holistic approach is recommended which presents the delinquent as a "bio-psycho-social entity."

E. I. Falstein discusses neuroses in adolescence and their treatment. In the first

part of his chapter the writer seems to endorse psychoanalysis in the pure and orthodox form is the only desirable kind of intervention, and at some length he develops and deplores the difficulties which the typical adolescent patient offers to this form of treatment. Later in this essay, however, one becomes aware of the many environmental maneuvers which the writer actually uses in his clinical practice. Thus, the therapist may have children spend some nights at his home, may take them to ball games, may hold long telephone conversations to try to influence school officials, may recommend foster home placement, and the like.

The last chapter, written by an orthopedic surgeon (W. Cooper) on emotional problems of the physically handicapped child, expresses this physician's complaint about the organistic approach of many of his colleagues. His examples, presented too briefly at times, demonstrate how surgery, physiotherapy and appliances are ineffective in the unmotivated, maladjusted or negativistic patient. Since each handicapped child and his family has emotional conflicts and problems these have to be taken into account in each and every case. The author recommends the use of social workers and psychiatrists in conjunction with orthopedic procedures. Thirteen cases, representing problems in childhood, adolescence and adulthood, are presented. Personality disturbances of the child resulting from the handicapping condition, parental attitude and social acceptance are discussed and explained, and suggestions made for their management.

Kurt Glaser